CONAM

We're Here for You

2025 Benefit Guide

This Guide Is Clickable

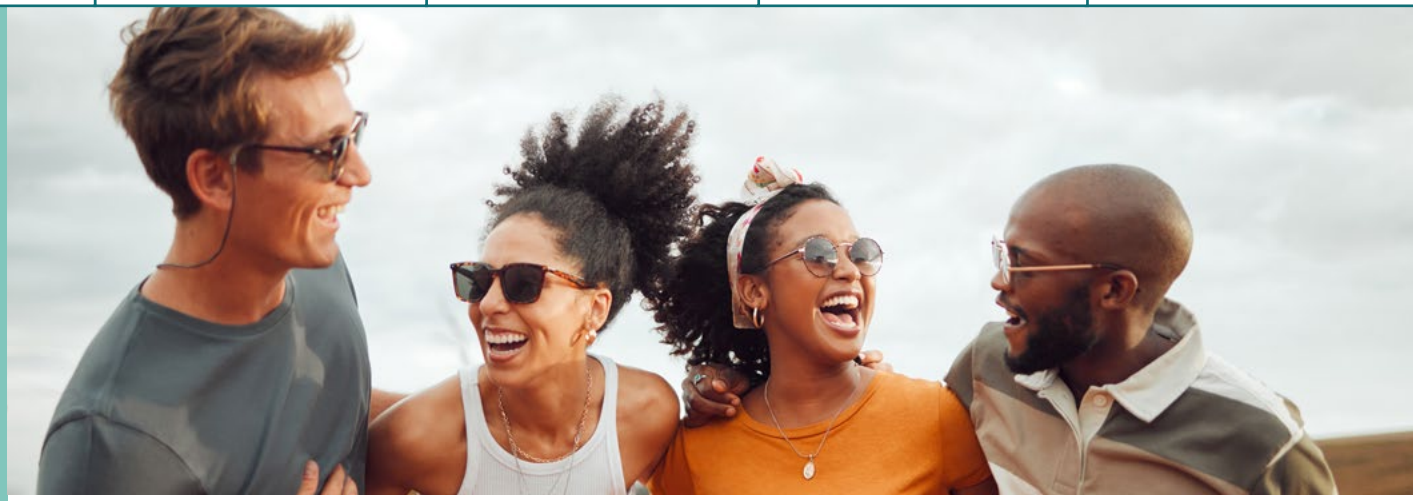
Welcome to Your CONAM Benefits!

At CONAM, we are proud of our culture of excellence. We know it's associates like you who make us great, and we're so thankful for that. Our best-in-class benefits package rewards you for all you do, and we hope you'll take advantage of it. From programs to protect your health, to financial guidance, and even fun perks to keep your work and life in balance, it's our way of saying thanks for all you do.

This guide shows you how to best utilize your benefits and choose the best options for you and your family. CONAM is grateful to offer these incredible programs.

See What's Inside

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see **page 33** for more details. Additionally, you have access to **SmartConnect**, a Medicare Resource which provides on-demand Medicare resources and live Medicare experts.



Getting Started

Associate Eligibility

Associates regularly scheduled to work 30 or more hours per week are eligible for medical, dental, vision, life insurance, disability, and voluntary benefits.

Employment Type	Eligibility
Regular associates	First of the month after one full month of employment
Temporary associates whose assignment is expected to be 60 days or longer	Medical, dental, and vision on the first of the month after one month of employment
Temporary associates whose temporary assignment has been determined to continue for more than 60 days or has been extended to 60 days or longer	Medical, dental, vision on the first of the month after such determination/ extension is made

All regular part-time and full-time associates are eligible for:

- The Employee Assistance Program (EAP)
- The CONAM 401(k) Plan*

**Temporary associates may enter the 401(k) plan after one year of service and 1,000 hours worked in one year. Monthly enrollments will be allowed thereafter.*

Medical Benefits Requirement

All associates are required to enroll in CONAM medical benefits (see page 6 for exemptions).

- All CA associates who are eligible for medical will automatically be enrolled in single coverage under the HMO Core Medical plan at no cost.
- All non-CA associates who are eligible for medical will automatically be enrolled in single coverage under the PPO Core Medical plan at no cost.
- You may choose to enroll your dependents and/or select a different medical plan option at an additional cost.

Getting Started (cont.)

Dependent Eligibility

You may enroll your eligible dependents in many of the same plans you choose for yourself. You must provide proof of dependent eligibility and verification documents must be received by the Benefits Department within 30 days of your date of hire or a qualified change in family status/life event (see **page 6**). Fax or email your documents to CONAM's Benefits Department at **(858) 614-7004** or **benefits@conam.com**.

Eligible dependents include:

- Legal spouse
- Domestic partner (medical, dental, vision, and voluntary life only)
- Children:
  - Up to age 26 (medical, dental, vision, and voluntary life only)
  - Children of a domestic partner up to age 26 (medical, dental, vision, and voluntary life only)
  - Unmarried, dependent children over age 26, who rely on you for support due to a disability (medical, dental, and vision only)

What You Need to Enroll Dependents

To enroll your dependents for benefits coverage, you must provide a copy of their Social Security card, so we may verify the information you enter directly into the CONAM Benefits website. As mandated by the Affordable Care Act (ACA), the name you provide for your dependent must be as it appears on the Social Security card. You may enter the information directly into the "Manage My Benefits" section of your UKG Self-Service Portal. Your personal information will be transmitted securely to the IRS and will remain confidential, as required by law.

You must also provide proof of dependent eligibility, such as a marriage license or birth certificate. The verification documents must be received by the Benefits Department within 30 days of your date of hire or qualified change in family status/life event. Fax or email your documents to CONAM's Benefits Department at **(858) 614-7004** or **benefits@conam.com**; otherwise, your request may be denied.

Virtual Benefits Fair

Please be sure to check out our Virtual Benefits Fair! This **interactive** online event will allow you to learn more about each of our plans and receive assistance with helping to build the perfect benefits package for you and your family. You can enjoy all the perks of an in-person benefits fair, from the comfort of home!

Enrolling & Making Changes

You have three opportunities to enroll in or make changes to your benefits:

1. Within 30 days of your hire date.
2. During the annual open enrollment period.
3. Within 30 days of a qualified change in family status/life event.

The choices you make during these times will stay in effect for the remainder of the plan year (January 1 - December 31). It's important to review your benefit options and choose the best coverage for you and your family.

What is a Qualified Change in Family Status/Life Event?

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a dependent
- Loss or gain of other health coverage for you and/or dependents
- Change in employment status
- Change in Medicaid/Medicare eligibility for you or a dependent
- Receipt of a Qualified Medical Child Support Order

Keep in mind you will be required to provide supporting documentation, such as a birth certificate or marriage certificate, to prove your dependent's eligibility.

New to CONAM?

Here's what you need to know about enrolling in your benefits:

1. You must enroll in benefits within 30 days of your hire date. CONAM provides company-paid core benefits that cannot be waived, and you will be automatically enrolled in these benefits.
2. **If you do not choose a medical plan within 30 days of your hire date, you will be automatically enrolled in the Associate-only HMO Core plan (for California associates) or the PPO Core plan (for non-California associates), without dependent coverage.**
   - » Associates have the option of waiving medical coverage if they have health coverage through a spouse, domestic partner, or parent; or are eligible for or have Medicare coverage.
   - » Associates will be required to complete a Health Insurance Waiver and provide proof of coverage within 30 days of hire or life event eligibility date. Proof of coverage can be a medical insurance card or notice of coverage from the spouse, domestic partner or parent's employer or insurance vendor. Associates who fail to provide the requested documentation will be denied the waiver and automatically enrolled into the employer-paid plan, at the lowest level of coverage. Associates will be required to waive medical coverage and provide proof of coverage every plan year.
3. Your next opportunity to make changes will be the next annual open enrollment with coverage effective January 1, unless you experience a qualified change in family status.

How to Enroll

1. **Review Your Options**
   Use this benefit guide to compare your options and evaluate plan costs and potential savings.

2. **Enroll Online through UKG**
   - Navigate to the "Myself" menu and click on "Manage My Benefits."
   - Click on "Benefits."
   - Click on "Shop and Enroll in Benefits."
   - Verify your personal information. Contact the Benefits Department if anything is incorrect.
   - Enter information for your eligible dependents.
   - Make your benefit selections.
   - Make sure to click "Checkout" to finalize your enrollment.

3. **Confirm Your Elections**
   Review your confirmation statement carefully to make sure your benefits and dependent information are correct.

   Note: You are able to make changes to your benefits until you click "Checkout" from October 28 through November 16, 2024. If you finalized your selections, you can request a change by contacting Benefits at **benefits@conam.com** before November 16. Starting November 17, 2024, your next opportunity to make changes will be the next annual open enrollment with coverage effective January 1, 2026, unless you experience a qualified change in family status/life event.

When Coverage Ends

If you are no longer eligible for CONAM benefits—due to termination of employment, reduction of hours, or leave of absence—you still have options to obtain the coverage you need.

Benefit	End of Coverage	Option(s) to Continue
Medical, Dental, Vision, & EAP	Benefits end on the last day of the month in which your eligibility for the benefit ends.	COBRA
Health Care FSA	Benefits end on the last day of employment. You have **60 days** after termination to submit any claims incurred prior to termination, for reimbursement of any unclaimed balance in your account.	
Dependent Care FSA	Benefits end on the last day of employment. You have **60 days** after the plan year ends to submit any claims incurred prior to the end of the plan year **(12/31)** for reimbursement of any unclaimed balance in your account.	None
Disability	If disabled, your coverage will continue. If not disabled, benefits end on the last day of employment.	
Critical Illness, Hospital Indemnity, Accident Insurance, & Identity Theft	Benefits end on the last day of the month in which your eligibility for the benefit ends.	Apply for an individual policy
Life and AD&D	Benefits end on the last day of employment.	
401(k)	Contributions end when your employment ends.	Depending on ending balance, associates can: ▪ Leave existing funds in the CONAM plan; or ▪ Roll over into another qualified plan; or ▪ Take a cash distribution

Valuable Health & Wellness Resources

Teladoc

(800) 835-2362 | blueshieldca.com/teladoc

Get quality care whenever you need it, no matter where you are! Teladoc gives you 24/7 access to licensed doctors for non-emergency conditions, right from the palm of your hand.

You can use your phone or computer to:

- Get general medical consultations with a licensed doctor for issues like sore throats, flu, sinus infections and more for no charge per visit.
- Connect with a mental health professional 7 days a week, for no charge.
- Get a dermatology consultation for skin issues such as eczema, acne, or rashes; upload a photo online and get a custom treatment plan for $85 or less.

Mental Health Consultations

Visit **blueshieldca.com/teladoc** to register or log in and answer a few questions about your needs. Then, request an appointment. Download the Blue Shield of California mobile app to access care from anywhere. Please note that mental health appointments must be scheduled in advance.

Health and Lifestyle Programs

Wellvolution | (866) 671-9644 | www.wellvolution.com

Wellvolution makes it easier to make healthier choices with your diet, exercise, sleep, and overall health. Through this no cost program, you have 24/7 access to health providers and well-being apps to help you live your best life possible.

Programs available include:

Emotional Well-being
Headspace and Headspace Care are available as 12-month programs to help you manage sleep, stress, anxiety, and depression, and boost resilience.

Diabetes Prevention
Coaching and digital tools like a Fitbit to track your success across a 12-month program for losing weight, feeling healthier, and reducing your risk of chronic disease.

Diabetes Care & Hypertension
Programs up to 18 months for treating common conditions, such as diabetes, hypertension, and heart disease.

Weight Management
Get a personalized plan, clinically proven to help you create better eating and fitness habits, and lose weight through access to a 12-month program.

Tobacco & Vaping Cessation
Programs include nicotine replacement therapy in the form of a patch, lozenge, or gum. A two-month supply can be delivered to your home.

Physical Therapy & Fitness
Personalized digital therapy and health programs to reduce pain and increase strength. No matter your pain level, there is a program for you.

Valuable Health & Wellness Resources (cont.)

Employee Assistance Program (EAP)

Cigna WorkLifeMatters I (877) 622-4327 I **mycigna.com** I ID: CONAM

When you need help with work, home, personal, or family issues, the Cigna WorkLifeMatters EAP offers you and your family a variety of **free and confidential** services and value-added programs.

Around-the-Clock Support	Face-to-Face Counseling	Family Resources	Managing Daily Life	Financial and Legal Services
If you have a question or need a listening ear, any time of the day or night, the EAP's professional counselors are available to take your call.	Your EAP offers referrals for services, including 6 face-to-face counseling sessions.	Manage your family's needs with the EAP's parenting, childcare, and elder care resources and guidance.	Access tools and useful information to help you juggle the demands of work, family challenges, health issues, and your ever-growing to-do list.	Whether you need help with a monthly budget, long-term savings strategies, or a legal question, the EAP gives you information, resources, and access to consultations with experts.

Health Advocacy

Carenet I (833) 968-1775 I **myadvocateservices.com**

Insurance coverage and processes can be complicated. Carenet Health is designed to provide support when you need it most. When you reach out to Carenet Health, you will be connected to an advocate who will help you make informed health care decisions and save money.

Your advocate can help you:

- Locate providers
- Schedule appointments
- Uncover claims and billing errors
- Explain medical conditions and treatments
- Clarify Medicare, Medicaid, and Medicare Supplement plans

Medicare Resource

SmartConnect | (833) 460-5273 | **gps.smartmatch.com/conam**

SmartConnect is a program for working or retiring adults (and their family members) who are Medicare-eligible and want to explore the benefits. They can connect you to education through on-demand resources and live Medicare experts. SmartConnect offers insurance plan cost comparisons and enrollment services at no cost.

CONAM Perks Just for You!

benefits@conam.com

The following programs are available to CONAM associates. Find out more information on the websites provided below. Email the CONAM benefits team for access codes and other information.

Tickets at Work
Discounts on movie tickets, theme parks, hotels, tours, Broadway and Vegas shows, and more. **ticketsatwork.com**

HD Supply
Access to the lowest catalog price of a broad range of maintenance products. **hdsupplysolutions.com**

Office Depot
The Office Depot discount program can be used in store only, email the Benefits Department for additional information.

Dell Computer Employee Purchase Program
Access to discounts on personal purchases of PCs, tablets, and other PC related items. **dell.com/mpp/CONAM**

CDW Computers Employee Purchase Program
Get discounts on personal purchases of PCs, tablets, and other PC related items. **cdw.com/epp**

Verizon
Access to employee-exclusive discounts. **verizonwireless.com/discounts**

T-Mobile
Get employee-exclusive discounts. **t-mo.co/330cnnK**

Benefits Terms & Definitions

To better understand your coverage, you should be familiar with benefits vocabulary. Take a moment to review these terms, which may be referenced throughout this guide.

Balance Bill

When a health care provider bills a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

Copay

A fixed dollar amount you pay the provider at the time of service.

Coinsurance

The percentage paid for a covered service, shared by you and the plan. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

Deductible

The amount you pay each plan year before the plan begins paying benefits. Not all covered services are subject to the deductible.

Emergency Room Care

Care received at a hospital emergency room for life-threatening conditions.

Formulary

A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

In-Network Care

Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

Out-of-Network Care

Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase, and services may be subject to balance billing.

Out-of-Pocket Maximum (OOPM)

The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

Premium

The complete cost of your plans. You share this cost with your employer and pay your portion through regular paycheck deductions.

Preventive Care

Routine health care including annual physicals and screenings to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

Urgent Care

Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems. Visit urgent care for sudden illnesses or injuries that are not life-threatening.

Benefit Acronyms

AD&D
Accidental Death & Dismemberment

EAP
Employee Assistance Program

FSA
Flexible Spending Account

HMO
Health Maintenance Organization

LTD
Long-Term Disability

PPO
Preferred Provider Organization

STD
Short-Term Disability

SBC
Summary of Benefits and Coverage

Choose the Right Place to Go for Care

Need medical attention, but it's not a true emergency? Save time and money by using telemedicine services or visiting urgent care.

Emergency room costs are expensive, and visits can take hours! Telemedicine services and urgent care centers provide quality care just like the ER, but you could save hundreds of dollars and hours of time in the waiting room for non-life-threatening issues.

$ **Teladoc** (Non-Life-Threatening) 	**$** **CVS & Target Minute Clinics*** (Non-Life-Threatening) 	**$$** **Primary Care Provider (PCP)** (Non-Life-Threatening) 	**$$** **Urgent Care Center**** (Non-Life-Threatening) 	**$$$** **Emergency Room** (Life-Threatening) 
Benefit: ▪ No copay ▪ Speak to a doctor from anywhere ▪ Reduced waiting room time	**Benefit:** ▪ Low copay ▪ In-person examination ▪ Same-day visits often available	**Benefit:** ▪ Low copay ▪ In-person examination ▪ Familiarity with your history	**Benefit:** ▪ Lower cost than an ER visit ▪ Same-day visits often available ▪ Highly accessible, close locations available	**Benefit:** ▪ Necessary for life-threatening conditions ▪ Open 24/7/365 ▪ Equipped to handle most severe medical situations
Reasons to go: ▪ Headaches ▪ Fever & flu symptoms ▪ Cough, cold & sore throat ▪ Skin irritations & rashes	**Reasons to go:** ▪ Fever & flu symptoms ▪ Earaches & infections ▪ Cough, cold & sore throat ▪ Skin irritations & rashes	**Reasons to go:** ▪ Preventive care ▪ Regular treatment for chronic conditions ▪ Abdominal pain ▪ Skin irritations & rashes	**Reasons to go:** ▪ Minor cuts, bumps, sprains & burns ▪ Allergic reactions ▪ Urinary tract infections ▪ Back & joint pain	**Reasons to go:** ▪ Seizure or loss of consciousness ▪ Severe cuts & burns ▪ Uncontrolled bleeding ▪ Heart attack or chest pain

**CVS minute clinic is only available to PPO members.*

***HMO members in their home service area must seek care at an urgent care center affiliated with their medical group.*

Blue Shield of California Medical Benefits

California & Non-California Associates

We offer four medical plans through Blue Shield of California, giving you the flexibility to select the coverage that best meets your needs and those of your family. Choose from our HMO and PPO plans listed below:

- **HMO Core - California associates only:**
  - In-network coverage only
  - Single coverage for eligible associates available at no cost
  - Lowest premiums for dependent coverage
  - Referral from PCP required to see specialist
- **PPO Core:**
  - Single coverage for eligible associates available at no cost
  - Lowest dependent premiums
- **PPO Preferred:**
  - Higher level of coverage than PPO Core plan
  - Slightly higher premiums
- **PPO Plus:**
  - Highest level of coverage
  - Lower out-of-pocket costs for copays and coinsurance
  - Highest premiums

To help you make an informed decision, a plan comparison chart is included on the **next page**.

Find an In-Network Provider

Blue Shield of California

HMO Plan
blueshieldca.com/networkhmo

PPO Plans
blueshieldca.com/pponetwork

Out-of-State
provider.bcbs.com

Find a Doctor Video
vimeo.com/showcase/watchfindadoctor

Blue Shield of California Medical Plan Comparison

(855) 599-2650 | blueshieldca.com

Plan Features	HMO Core	PPO Core		PPO Preferred		PPO Plus	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual/Family	$2,500 / $5,000	$2,500 / $5,000	$10,000 / $20,000	$2,000 / $4,000	$10,000 / $20,000	$1,000 / $2,000	$10,000 / $20,000
Annual Out-of-Pocket Maximum Individual/Family	$6,350 / $12,700	$6,350 / $12,700	$15,000 / $30,000	$6,000 / $12,000	$15,000 / $30,000	$4,000 / $8,000	$15,000 / $30,000
	You pay:	**You pay:**		**You pay:**		**You pay:**	
Preventive Care Visit	Covered in full	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Virtual Care Visit (Teladoc)	No charge	No charge	Not covered*	No charge	Not covered*	No charge	Not covered*
Primary/Specialist Visit	$35 copay	$35 copay	50% after deductible	$25 copay	50% after deductible	$20 copay	50% after deductible
Lab & X-ray	No charge	No charge	50% after deductible	No charge	50% after deductible	No charge	50% after deductible
Urgent Care	$35 copay	$35 copay	50% after deductible	$25 copay	50% after deductible	$20 copay	50% after deductible
Emergency Room	$50 copay	$50 copay, then 30%		$50 copay, then 20%		$50 copay, then 10%	
Inpatient Hospital Services/ Inpatient Mental Health & Substance Abuse	$100 copay, then 30% after deductible	$100 copay, then 30% after deductible	50% after deductible ($500/day max benefit)	$100 copay, then 20% after deductible	50% after deductible ($500/day max benefit)	$100 copay, then 10% after deductible	50% after deductible ($500/day max benefit)
Outpatient Surgery	30% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible
Chiropractic & Acupuncture (30 combined visits per year)	$10 copay (20 visits per year)	Chiro: $30 copay (20 visits/year) Acu: $35 copay (24 visits/year)	50% after deductible	Chiro: $25 copay (20 visits/year) Acu: $25 copay (24 visits/year)	50% after deductible	Chiro: $20 copay (20 visits/year) Acu: $20 copay (24 visits/year)	50% after deductible

**Charge based on provider status in Blue Shield of California network.*

Note: *If you do not elect coverage during your initial eligibility period, you will be enrolled in the HMO Core Plan (CA associates) or the PPO Core Plan (non-CA associates).*

Blue Shield of California Prescription Benefits

(855) 599-2650 | blueshieldca.com/pharmacy

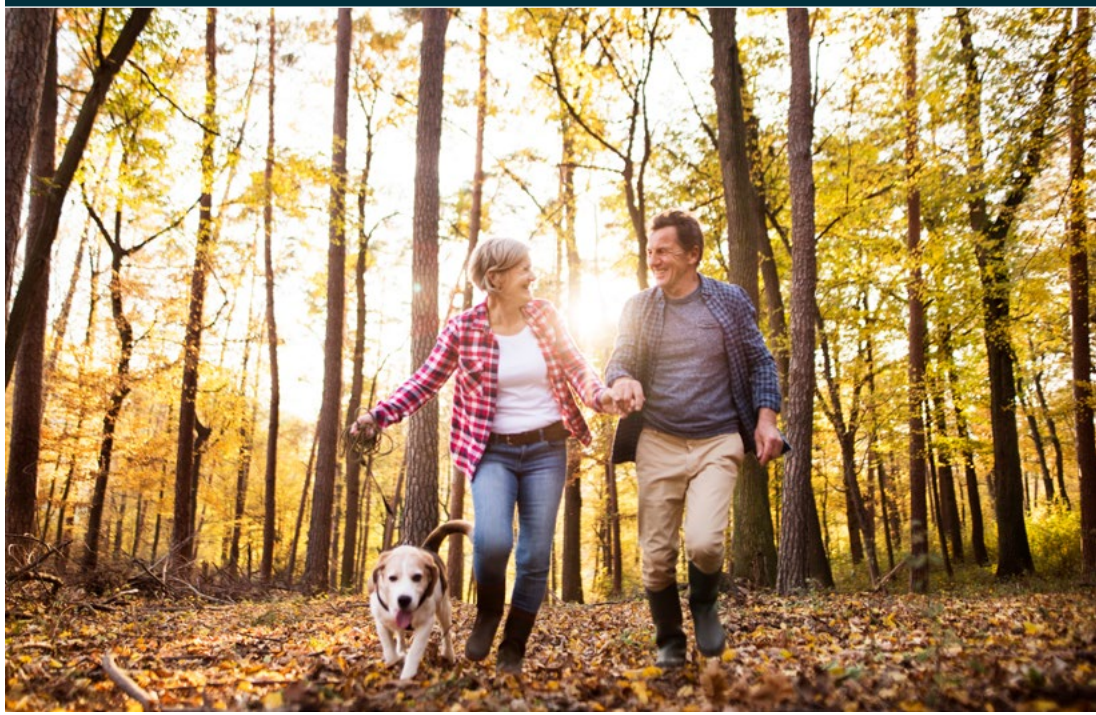
All our medical plans include the same prescription drug coverage, through Blue Shield of California. For more information on which tier level your prescription drug falls under, search the formulary list at **blueshieldca.com/pharmacy** or contact Blue Shield of California Member Services.

Prescription Benefits for Blue Shield of California Medical Plans (In-Network)*	
Retail Pharmacy (30-day supply)	
Contraceptive & Value-Based Tier Drugs	No charge
Tier 1	$15 copay
Tier 2	$30 copay
Tier 3	$50 copay
Tier 4	30% up to $200
Specialty	30% up to $200
Retail and Mail-Order Pharmacy (90-day supply)	
Contraceptive & Value-Based Tier Drugs	No charge
Tier 1	$30 copay
Tier 2	$60 copay
Tier 3	$100 copay
Tier 4	30% up to $400
Specialty	Not covered

**Review benefit summaries for out-of-network prescription coverage.*

Prior Authorization/Step Therapy

Certain medications may require prior authorization from Blue Shield of California before they are covered. Some medications that are less expensive, but just as clinically effective, may also need to be prescribed first before more costly medications may be covered (step therapy).



SIMNSA Medical Benefits

(800) 424-4652 | simnsa.com

To provide an alternate medical plan for our diverse associate population, we offer the SIMNSA medical plan for employees and their families who reside in San Diego and Imperial Counties. Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) is comprehensive health care for U.S. employees who prefer to receive healthcare services in Mexico.

Plan Features	HMO
	In-Network Only
Annual Deductible Individual/Family	$0 / $0
Annual Out-of-Pocket Maximum Individual/Family	$6,350 / $12,700
	You pay:
Preventive Care Visit	Covered in full
Virtual Care Visit (Teladoc)	Covered in full
Primary/Specialist Visit	$5 copay
Lab & X-ray	No charge
Urgent Care	$25 copay
Emergency Room	$250 copay
Inpatient Hospital Services/Inpatient Mental Health & Substance Abuse	No charge
Outpatient Surgery	No charge
Chiropractic & Acupuncture (24 visits per year)	$10 copay (unlimited)
Prescription Drugs	$5 copay

Note: *If you do not elect coverage during your initial eligibility period, you will be enrolled in the HMO Core Plan (CA associates) or the PPO Core Plan (non-CA associates).*

Find an In-Network Provider

SIMNSA

- Go to **simnsa.com**.
- Click on “Providers List” under “Providers & Facilities.”
- Under “Provider Search,” select “All” for network.
- Enter the type of facility and/or specialty and click “Start Search.”

Voluntary Benefits

Voluntary worksite benefits help protect your finances from unexpected events. These plans are affordable, and the premiums are conveniently deducted from your paycheck. You may choose to insure yourself, your spouse, and your children. No health questions are required.

Accident Insurance

(800) 521-3535 | **allstate.com**

Allstate accident insurance helps pay for expenses related to unexpected accidents and injuries. The benefit amount is determined by the injury and medical care required and is paid directly to you in a lump sum.

Critical Illness

(800) 521-3535 | **allstate.com**

Allstate critical illness insurance helps pay for expenses related to the diagnosis of a critical illness such as a heart attack, coma, kidney failure, or cancer. The benefit amount is determined by the type of illness and is paid directly to you in a lump sum. If you have a health issue you've been treated for prior to the start date of your policy (a pre-existing condition), the condition may limit plan coverage.

Hospital Indemnity

(800) 521-3535 | **allstate.com**

If you are hospitalized, Allstate's hospital indemnity coverage provides a lump sum benefit to help you cover unexpected costs. The benefit amount is determined by the reason for, and length of, your hospitalization.

Identity Theft Protection

(800) 789-2720 | **myaip.com**

This program, through Allstate Identity Protection, provides access to personal case managers who offer step-by-step assistance and guidance if you experience identity theft. You also receive credit monitoring, credit card fraud assistance, and help with emergency travel arrangements.

Pet Insurance and Discount Plan

Pets Best | (888) 984-8700 | **petsbest.com/CONAMPET**

Pet Benefits Solutions | (800)-891-2565 | **customercare@petbenefits.com**

CONAM understands your family extends to your furry friends. Keep them healthy and protected too. We offer a selection of flexible and affordable insurance programs from Pets Best to aid in the cost of veterinary care. Additionally, the Pet Benefit Solutions discount program can help provide your pet with quality supplies and support.

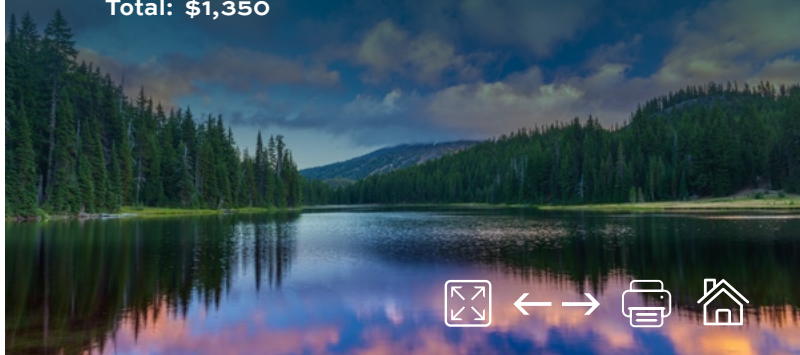
How Voluntary Benefits Could Work for You

Here's an example of how voluntary benefits can work together to fill in gaps in your regular medical coverage and provide financial protection.

Grace elects Accident insurance. While she is playing soccer, she is hit in the head and knocked unconscious. At the hospital, the doctor orders an MRI and diagnoses her with a concussion. Here's a look at the lump sum benefit Grace could receive from her accident:

- Ambulance: $600
- Emergency Room Treatment: $150
- MRI: $400
- Concussion: $200

Total: $1,350



NurseHelp 24/7

Blue Shield of California | (877) 304-0504 | **blueshieldca.com/care**

Call NurseHelp 24/7 and talk with a registered nurse anytime you have health related questions. Experienced nurses can help you figure out how you can care for yourself, evaluate treatment options, and help you determine whether to see a doctor.

Preventive Care

Blue Shield of California | (855) 599-2650 | **blueshieldca.com/preventive**

All medical plans cover preventive care services, at no cost to you, when you visit in-network providers. A partial list of covered preventive services is noted below:

- Annual physical exams for adults and children
- Diabetes, blood pressure, and cholesterol screening for adults 18 and over
- Autism screening for children at 18 and 24 months
- Mammograms for women 40 and over
- Colorectal cancer screening for adults ages 45-75

Note: In order to receive preventive care at no cost, the preventive services must be the purpose of your doctor's visit. If diagnostic services are completed during your preventive care, or if preventive screenings (such as a cholesterol test) are administered during a diagnostic office visit, the plan may require you to pay some of the cost.

Mental Health Care

Blue Shield of California | (855) 599-2650 | **blueshieldca.com/mentalhealth**

LifeReferrals

Whether you need to sleep better or manage the stress of life's challenges, we have mental health care available - at no additional cost to you.

Headspace Care™

On demand mental health support day or night. Easy access to care - no matter where you are, when you need it, or what you're going through. Headspace Care offers on-demand, confidential mental healthcare through coaching and self-guided activities. Need to chat on the weekend? or at 3am on a holiday? Headspace Care is available for in-the-moment support and goes where your smartphone goes.

How it Works

1. **Create a Wellvolution account:** Blue Shield will confirm you're qualified to receive the program at no additional cost.
2. **Complete your health profile:** Answer a few questions to confirm which program is right for you.
3. **Experience the benefits:** Download the app and get support at your fingertips for better mental health.

Maven Family & Fertility Benefits

At CONAM, we understand that family is at the heart of what makes life meaningful, fulfilling, and complete. We recognize that the path to parenthood can be both exciting and challenging, and we're here for you every step of the way. No matter where you are on your reproductive and family health journey, Maven is here. Get free 24/7 virtual access to top-rated providers via unlimited video appointments, messaging, and classes—all from the comfort of your home. Get started by visiting **blueshieldca.com/maven**.

Dental Coverage

Cigna | (800) 244-6224 | **cigna.com**
SIMNSA | (800) 424-4652 | **simnsa.com**

DHMO Dental Plan

- The plan covers in-network services only. If you visit an out-of-network provider, you will pay the full cost of services.
- You must select a primary dentist who will coordinate your dental care needs, including referrals to specialists.
- The plan has no deductible, annual benefit maximum, or claim forms. Copays are required for services, but preventive care is free.

PPO Dental Plans

- You may visit any dentist of your choice, but you'll receive the highest coverage when you visit in-network providers.
- You will pay an annual deductible before you receive select services and you have an annual maximum benefit.
- The High Plan offers the highest level of coverage but has higher premiums.
- PPO Dental Wellness Benefit: Members who receive preventive treatment this year will be able to **increase their annual maximum benefit by $100 for the next plan year!** ($300 maximum increase for each member for the life of the plan.)

SIMNSA Dental Plan

- The SIMNSA dental plan is available for associates and their families who reside in San Diego and Imperial Counties.

Plan Features	DHMO	PPO Low		PPO High		SIMNSA Plan
	In-Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network
Calendar Year Deductible (waived for Preventive Services)	None	$50 individual / $150 family		$50 individual / $150 family		None
Calendar Year Benefit Maximum	None	$1,250 per person		$1,500 per person		None
Orthodontia Lifetime Maximum	None	$1,250		$1,500		NA
	You pay:	**You pay:**		**You pay:**		**You pay:**
Diagnostic & Preventive Services (e.g., x-rays, cleanings, exams)	No charge	No charge	20%	No charge		No charge
Basic & Restorative Services (e.g., fillings, extractions, root canals)	Various copays	50%		10%	20%	Various copays
Major Services (e.g., dentures, crowns, bridges)	Various copays	70%		40%	50%	Various copays
Orthodontia (adult and children)	Various copays	50%		50%		$50 copay

**For out-of-network services, members pay applicable coinsurance plus any amount that exceeds the usual, customary, and reasonable charge.*

Find an In-Network Provider

CIGNA

- Go to **cigna.com**.
- Select "Find a Doctor, Dentist, or Facility."
- When asked "How are you covered?", select "Employer or School."
- Enter your location, enter "Dentist" as doctor type, then "Continue as guest," and select your plan to begin search.

SIMNSA

- Go to **simnsa.com**.
- Click on "Read More" under "Providers & Facilities."
- Under "Provider Search," select "All" for network.
- Enter the type of facility and/or specialty and click "Start Search."

Vision Coverage

VSP | (800) 877-7195 | **vsp.com**

The vision plan offers an extensive network of optometrists and vision care specialists. Remember, you'll save money by visiting in-network providers.

You will not receive a VSP ID card, as one is not required to receive service. Simply call a VSP network doctor to schedule an appointment and tell the doctor you are a VSP member.

Schedule of Benefits	Vision Service Plan		
	Exam Plus	Signature	
	In-Network	In-Network	Out-of-Network
Exam every 12 months	$10 copay	$20 copay	Reimbursed up to $50
Materials Copay	N/A	$20 copay	See schedule below
Frames every 12 months	20% discount	$130 allowance plus 20% off the amount over allowance; Costco: $70 allowance	Reimbursed up to $70
Lenses every 12 months Single Bifocal Trifocal	20% discount	Covered in full after materials copay	Reimbursed up to: $50 $75 $100
Contact Lenses every 12 months (in lieu of lenses and frames)	15% discount	$130 allowance	Reimbursed up to $105

Your Cost for Coverage

CONAM pays 100% of the premium cost for our CA associates' HMO Core and HMO SIMNSA Medical plans and 100% of the cost for our non-CA associates' PPO Core Medical plan. The Exam Plus Vision plan is covered at 100%, if elected by the associate.

CONAM will continue to pay a portion of the dependent cost for medical, dental, and vision coverage. The portion that you pay for your medical, dental, and vision coverage as well as flexible spending accounts, is deducted from your paycheck on a pre-tax basis.*

Your **per paycheck** deductions for medical, dental, and vision are shown here (24 deductions per year).

Contribution amounts are effective as of January 1, 2025. For questions, contact the CONAM Benefits Department at* **Benefits@CONAM.com.

Benefit Plan	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate + Family
Medical (CA Associates)				
HMO Core (In-Network Only)	$0.00	$220.30	$168.57	$286.07
PPO Core (Full Network)	$26.13	$252.44	$196.72	$323.28
PPO Preferred (Full Network)	$41.47	$279.95	$220.11	$358.36
PPO Plus (Full Network)	$92.31	$323.97	$262.06	$472.54
HMO SIMNSA (In-Network Only)	$0.00	$111.70	$109.52	$186.73
Medical (Non-CA Associates)				
PPO Core (Full Network)	$0.00	$252.44	$196.72	$323.28
PPO Preferred (Full Network)	$41.47	$279.95	$220.11	$358.36
PPO Plus (Full Network)	$92.31	$323.97	$262.06	$472.54
Dental				
DHMO	$3.46	$8.90	$9.51	$16.15
PPO Low	$11.87	$26.15	$23.16	$41.65
PPO High	$23.42	$50.01	$44.65	$80.40
DHMO SIMNSA	$5.14	$12.60	$17.10	$23.22
Vision				
Exam Plus	$0.00	$0.40	$0.42	$1.04
Signature	$4.11	$6.91	$7.07	$11.76

Flexible Spending Accounts (FSAs)

P&A Group I (800) 688-2611 I **padmin.com**

Flexible spending accounts (FSAs), administered by P&A Group, offer a smart way to stretch your dollars by setting aside pre-tax money to pay for eligible health and dependent care expenses. Each year, you must elect the annual amount you want to contribute to each account. Your contributions will be deducted pre-tax from your paycheck, which helps reduce your taxable income.

	Health Care FSA	Dependent Care FSA
Annual Contribution Limit*	**$3,300**	**$5,000** (**$2,500** if married and filing separately)
Rollover Options	Yes, you may roll over up to **$660** of unused funds when you re-enroll	Unused funds do not roll over
Eligible Expenses**	Health care plan deductibles, copays, coinsurance, and prescriptions, including dental and vision hardware and expenses	Daycare for children age 12 and under, disabled children, and dependent adults
Availability of Funds	The full annual amount you elect is available on your plan effective date	You can be reimbursed up to the amount available in your account
Payment or Reimbursement Options	Debit card or reimbursement	Reimbursement
Deadline for Services	Services must be incurred by 12/31/2025, with reimbursement requests submitted by 3/16/26	Services must be incurred by 12/31/2025, with reimbursement requests submitted by 3/16/26
Deadline for Submission for Reimbursement	60 days after the plan year, or your coverage, ends	60 days after the plan year ends
Coverage Ends	When no longer employed at CONAM	When no longer employed at CONAM

IRS limits may change. Please refer to* **www.irs.gov *for the most up-to-date IRS limits, rules, and regulations.*
***For a complete list of eligible expenses, refer to* **IRS Publication 502: Medical and Dental Expenses**.

Online FSA Access

- Visit **padmin.com** to view your account balance or receipt history.
- Download a claim form.
- Submit claims electronically.
- Chat live online with a customer service rep.

Payment and Reimbursement

Use your FSA debit card or submit claims to:

- Mail: 6400 Main Street, Suite 210 Williamsville, NY 14221
- Phone: **(800) 688-2611**
- Fax: **(877) 855-7105**
- Online: **padmin.com**

Life and AD&D Insurance

New York Life I (800) 362-4462 I mynylgbs.com

Life and accidental death & dismemberment (AD&D) insurance, through New York Life, provides financial security to you and your family if you pass away or become seriously injured.

Basic Life and AD&D Insurance

CONAM wants to make sure you are protected financially when you need it most, so we provide you with life insurance coverage at **no cost to you**. For all regular, benefits-eligible associates, the benefit is equal to $25,000 or one times your annual salary up to $50,000, whichever is greater. Your life insurance benefit reduces at age 70.

Voluntary Life and AD&D Insurance

In addition to basic life and AD&D, you may buy voluntary life and AD&D coverage at discounted rates. If you elect coverage for yourself, you may also enroll in coverage for your spouse and/or your child(ren).

Benefit Features	Voluntary Life and AD&D Options*		
	Associate	Spouse	Dependent Child(ren) (up to age 26)
Coverage Options	$10,000 increments	$5,000 increments	$10,000
Maximum	$500,000	$250,000 (cannot exceed 50% of the associate's coverage)	$10,000
Guarantee Issue Amount	$200,000	$30,000	
Guarantee Issue Period	Within 30 days of benefits eligibility or a qualified change in family status/life event		

**Evidence of Insurability (EOI) may be required if you elect coverage over the guarantee issue amount.*

Choosing a Beneficiary

You may choose anyone to be the beneficiary of your life and AD&D policy in the event of your death or serious injury. Review your beneficiary designation periodically to ensure it reflects your current wishes.

What Is EOI?

Evidence of Insurability (EOI) is the process of providing health information to qualify for certain types of insurance coverage. If you elect voluntary life and AD&D coverage above the guarantee issue amount or after the guarantee issue period, you will be required to submit a health questionnaire (in some cases, a physical exam may be required).

Disability Coverage

New York Life I (800) 362-4462 I mynylgbs.com

If you experience an injury or illness that prevents you from working, disability coverage provides partial income replacement to assist you financially.

Short-Term Disability (STD)

CONAM provides associates outside of California with 8 weeks of STD insurance, through New York Life, at no cost. If you live in California, STD insurance, also known as SDI, is provided to you by the state. All associates also have the option to purchase additional STD coverage to supplement the CONAM-paid STD benefit or CA SDI benefit.

If you are an associate in the state of Colorado, Oregon, or Washington, STD benefits will be offered through the state, and you have the option to purchase additional STD coverage to supplement your state provided benefit.

Long-Term Disability (LTD)

LTD pays you a portion of your earnings if you cannot work for an extended period of time, due to a disabling illness or injury. Corporate and regional associates are provided LTD at no cost. This coverage provides you with income if you are unable to work due to illness or injury.

Voluntary Long-Term Disability

CONAM provides community associates the option to purchase voluntary LTD with options of a 60-day and 180-day elimination period. The 60-day elimination period eliminates the potential for a gap in coverage between STD and LTD.

401(k) Retirement Plan

Empower | (800) 338-4015 | empowermyretirement.com

Being retirement ready is an important part of financial wellness. The CONAM 401(k) Plan, administered by Empower, offers a variety of investment options. The company generously matches your 401(k) contributions to help grow your retirement savings.

Eligibility

Regular and part-time associates may enroll on the first of the month after one month of employment. Temporary associates may enroll after one year of service and 1,000 hours worked in one year. When eligible, you may enroll in the 401(k) plan, designate beneficiaries, and allocate your asset distribution at any time. You do not need to wait for annual enrollment to make changes.

Company 401(k) Contributions

The key to a successful retirement is to start saving now! After one year of employment, CONAM will provide matching contributions to your 401(k) plan. Community associates will receive matching contributions for each pay period, while Corporate and Regional associates will receive an annual discretionary match. You are eligible for a match if all of the following apply:

- You have one year of service with CONAM.
- You defer into the plan during the match calculation period.
- You are not a Highly Compensated Associate (as defined by ERISA).

CONAM's matching contributions are fully vested after three years from your date of hire. When your employment with CONAM ends, only the vested portion of the employer match will be eligible for distribution, rollover, or withdrawal.

NFP Financial Education

(800) 959-0071 | retirementinfo@nfp.com

All CONAM associates have access to personalized investment guidance from NFP's licensed Education Specialists. The services are confidential and are offered at no cost.

401(k) Fast Facts

- In 2025, you may contribute from 1% to 100% of your compensation, up to the IRS maximum.
- If you are age 50 or over, you can make a "catch-up" contribution up to $7,500.
- If you are between the ages of 60 and 63, your catch-up contribution may total up to $10,000.
- You are fully vested after three years of service (including any prior service within 7 years of a re-hire date).

Helpful Tips on Saving for Retirement

- Start saving as soon as possible to grow your retirement account.
- Begin with small contributions, if necessary, and increase contributions over time.
- Understand investment returns may fluctuate.
- Let it sit. Avoid penalties by leaving funds in your 401(k) until retirement.
- If you change jobs, you can roll over your retirement account.

Your Benefit Contacts

Coverage	Contact	Policy Number	Phone	Website/Email
CONAM Benefits Enrollment	N/A	N/A	(858) 614-7255	**UKG Self-Service Portal**
Medical & Pharmacy	Blue Shield of California SIMNSA	W3000543 552	(855) 599-2650 (800) 424-4652	**blueshieldca.com/home** (Select "Login") **Simnsa.com** (Select "Login")
Mail Order Prescriptions	Blue Shield of California	W3000543	(855) 599-2650	**blueshieldca.com/home** (Select "Login")
Telemedicine	Blue Shield of California	W3000543	(800) 835-2362	**blueshieldca.com/teladoc**
Nurse Health Coach	Blue Shield of California	W3000543	(877) 304-0504	**blueshieldca.com/home** (Select "Login")
Health Care Referral & Advocacy	Carenet Health	MMA2021!	(833) 968-1775	**myadvocateservices.com**
Wellvolution	N/A	N/A	(866) 671-9644	**www.wellvolution.com**
Dental	Cigna SIMNSA	3337858 552	(800) 244-6224 (800) 424-4652	**cigna.com** **Simnsa.com**
Vision	VSP	12204057	(800) 877-7195	**vsp.com**
Life and AD&D	New York Life	Life: FLX969104 AD&D: OK970560	(800) 362-4462	**mynylgbs.com**
Disability	New York Life	STD: LK752554 LTD: LK966067	(800) 362-4462	**mynylgbs.com**
Employee Assistance Program (EAP)	Cigna	CONAM	(877) 622-4327	**cigna.com**
401(k)	Empower	524797-01	(800) 338-4015	**empowermyretirement.com**
Financial Education	NFP	N/A	(800) 959-0071	**retirementinfo@nfp.com**
Flexible Spending Accounts (FSA)	P&A Group	N/A	(800) 688-2611	**padmin.com**
Critical Illness & Accident	Allstate	G1429	(800) 521-3535	**Allstatebenefits.com/mybenefits**
Hospital Indemnity	Allstate	99370	(800) 521-3535	**Allstatebenefits.com/mybenefits**
Pet Insurance	Pets Best	24874885	(888) 984-8700	**Petsbest.com/CONAMPET**
Pet Discount Program	Pets Benefit Solutions	6184	(800) 891-2565	**customercare@petbenefits.com**
Identity Theft Protection	Allstate	N/A	(800) 789-2720	**myaip.com**
Secure Travel Assistance Services	Cigna	N/A	U.S.: (888) 226-4567 Non-U.S.: (202) 331-7635	N/A
Medicare Resource	SmartConnect	N/A	(833) 460-5273	**gps.smartmatch.com/conam**

This communication highlights some of your CONAM benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. CONAM reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

Mercer

CONAM Management

Open Enrollment Notices

Updated as of August 8, 2024

CONAM RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON.

PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their dependents. In all cases, the official plan documents govern and this Benefits Decision Guide is not, and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the CONAM summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is included in your enrollment packet. You may also request a paper copy by calling CONAM.

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

welcome to brighter

Important notice to employees from CONAM about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the CONAM Group medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2025 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with CONAM and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the CONAM prescription drug plans, you’ll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the CONAM Group plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop CONAM Group coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the CONAM Group plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with CONAM Group and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare

prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this CONAM Group coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Brittany Lachance, Senior Benefits Manager
3990 Ruffin Road, suite 100
San Diego, CA 92123
858-614-7261

Blachance@conam.com

Notice of Special Enrollment Rights for Medical plan coverage

As you know, if you have declined enrollment in CONAM's medical 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 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.

Academica 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 the CONAM 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

Women's Health and Cancer Rights Act 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, call your medical carrier at the phone number listed on the back of your ID card.

Newborns' and Mothers' Health Protection Act 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, call your medical carrier at the phone number listed on the back of your ID card.

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 or 1-866-614-6005	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 1-833-522-5582 TDD: 1-888-221-1590
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

CONAM 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 CONAM 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, Vision, EAP*. 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 CONAM as an employer — that's the way the HIPAA rules work. Different policies may apply to other CONAM 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 CONAM

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to CONAM for plan administration purposes. CONAM may need your health information to administer benefits under the Plan. CONAM agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources employees are the only CONAM 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 CONAM, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to CONAM, 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 or HMO, may disclose to CONAM information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that CONAM cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by CONAM 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 December 1, 2024. 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.

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, contact Benefits Department at **Benefits@CONAM.com** or 858-614-7255.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Benefits Department at **Benefits@CONAM.com** or 858-614-7255.

Provider-Choice rights notice

The Blue Shield of CA HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. *Until* you make this designation, Blue Shield of CA designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield of CA at 855-599-2650.

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

You do not need prior authorization from Blue Shield of CA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Shield of CA at 855-599-2650.

Fixed Indemnity Plan Notice

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Visit your carrier's website for more information about your rights under federal law:
Blue Shield of CA: https://www.blueshieldca.com/content/dam/bsca/en/member/docs/A55360COM0623-Notice-Patient-Protections-Against-Surprise-Billing.pdf

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Department at Benefits@CONAM.com or 858-614-7255.

[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.

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.

Company name: CONAM Management Corporation	Employer Identification Number (EIN): 95-3809553
Address: 3990 Ruffin Rd, Suite 100, San Diego, CA, 92123	Employer phone number: 858-614-7255
Who can we contact about employee health coverage at this job? Benefits@CONAM.com or 858-614-7255	

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

- As your employer, we offer a health plan to:
  - Please see page 4 and 5 of this benefit guide

- With respect to dependents:
  - Please see page 4 and 5 of this benefit guide

  ☒ 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.

  ** 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.