2023

BENEFITS GUIDE

CONVERGE
TECHNOLOGY SOLUTIONS

Table of Contents

Get Ready To Enroll

Enrollment Period

You have 30 days from your first day of eligibility to complete your benefits enrollment.

Who is Eligible?

Employees

You are eligible for benefits if you are classified by Converge as a full-time employee, regularly scheduled to work at least 30-hours per week.

Dependents

Depending on the benefit, your legal spouse, domestic partner and dependent children to age 26 may also be eligible for coverage.

- Domestic Partner means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that he or she is the employee's sole Domestic Partner and has been for 12 months or more; he or she is not related to the employee by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the employee.
- Dependent Children, under age 26 (natural, step, adopted, placed for adoption and eligible foster children). Children can be married and do not have to reside with you, be financially dependent on you or be students to qualify as dependents.
- Dependent Children, age 26 or older, who are physically or mentally disabled and covered under the Plan when they would otherwise lose coverage under the Plan due to age and who are dependent upon you for more than half of their financial support; proof of disability will be required.
- Dependent Children who must be provided medical, dental and/or vision coverage by Converge's plan as required by a Qualified Medical Child Support Order, up to the maximum age allowed by the Plan.

When are You Eligible?

Benefits for newly eligible and rehired employees become effective on the first of the month following the date of hire. If you have a qualified family event, you must make a change request within 30 days of the event, or you will not be able to change your elections until the next annual enrollment period. The change request must be consistent with the qualifying event.

Qualified Changes

The IRS provides strict regulations about changes to pretax elections during the plan year; however, changes are permitted under specific qualified family status changes, such as:

- Marriage, divorce or annulment
- Death of spouse or dependent
- Birth of a child, placement of a foster child or child for adoption with you, or assumption of legal guardianship of a child
- Change in your spouse's or dependent's employment status that affects benefits eligibility
- You or your spouse returns from unpaid leave of absence
- You or your dependent becomes eligible or loses eligibility for Medicare or Medicaid
- Change in your employment that affects benefits eligibility
- For a full list of qualifying changes, click here.

Nayya

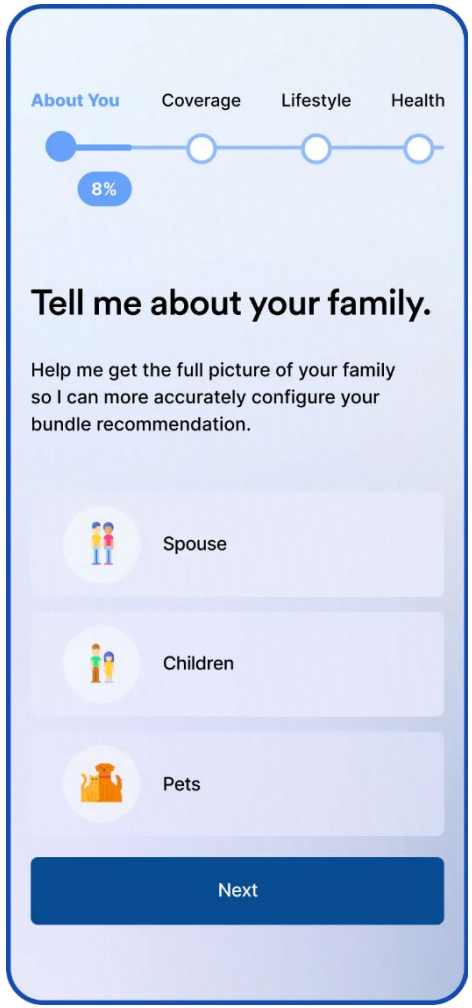
What's Nayya?
Nayya walks you through enrollment with a quick, step-by-step assessment to determine the right level of coverage based on your unique needs. With Nayya, you can complete enrollment in less than 10 minutes!

Powered by AI, billions of data points, and personal data, Nayya's technology transforms the way consumers choose their benefits. Personalization can mean the difference between a positive and negative outcome.

Let's Get Started

1. Your benefits enrollment experience kicks off with a welcome email from Nayya that provides instructions on how to claim your account. To access the Choose portal, please use the link you received via email or **scan the QR code to your right**.
2. Within the Choose assessment, you will be asked to provide your current medical insurance carrier, as an option. Once linked, Nayya will analyze your past insurance usage to determine the right level of benefits for you moving forward. You will then be asked to answer simple questions about your family, lifestyle, and any upcoming life changes you have planned, such as if you are getting married or having a baby.
3. After finishing the assessment, you will then be provided with your bundled benefits recommendations and directed to complete the enrollment process.

Nayya



Data Privacy
Nayya are SOC 2, HIPAA, and CCPA compliant so you can rest assured that your personal data is well protected.

Does Nayya share any of my healthcare information with my employer?
All individual employee data shared with Nayya is kept completely confidential and will not be provided to anyone, including employers. The data is solely for individual benefit recommendations.

Will my assessment responses be kept private?
Absolutely – your privacy is our top priority. Your employer will never see your responses and your health and financial information is kept private. Your answers are only used to personalize your recommendations so we can help you find the right care.

How to Enroll in Benefits | Paycom

Online
Go to paycom online and follow the steps found there.

App
The Paycom app makes it even easier to access Employee-Self Service on your mobile device with new features that include fingerprint login and notifications.

To enroll via the Paycom app, follow these steps:
1. Search **"Paycom"** on the **App Store** or **Google Play**.
2. Download the app.
3. Enter your **username, password** and **Social Security** number's last four digits.
4. If your device has fingerprint access, Face ID or a PIN, you can quickly access the app.
5. Click "**Login**."

How to Enroll in Your Benefits

Step 1
Log into the Paycom app. From the Notification Center or from the Benefits section, click the current year's Benefits Enrollment.

Step 2
Review initial instructions and click **"Start Enrollment."** Then, enter your personal information and any dependents or beneficiaries.

Step 3
After reading each benefit plan, choose your coverage, then elect either to enroll or decline.

Step 4
To complete enrollment, click **"Finalize,"** then **"Sign and Submit."**

MEDICAL OVERVIEW

Medical Benefits | Open Access Plans | Anthem

What Is an Open Access Plan (OAP)?

The term Open Access Plan or OAP refers to a health insurance plan with a copays and deductibles for medical expenses. These types of plans provide in and out of network coverage and allow you to see a specialist without a referral. Plans fully cover routine preventive care.

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Open Access Plus Plans (OAP)

Key Features

- The two OAP plan options are the $1,000 and $2,500 plans.
- Both plans result in out-of-paycheck cost.
- Lower deductibles than the HDHP.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per member deductible and per member out-of-pocket maximum.
- Amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum.
- No one member will pay more than the per member deductible or per member out-of-pocket maximum.
- Your copays, coinsurance and deductible count toward your out-of-pocket amount(s).
- Copays for routine services, doctor's office visits and prescriptions.
- Coinsurance counts toward your out-of-pocket maximum which includes office visit and prescription copays, deductible and coinsurance.
- Free in-network preventive care per the Affordable Care Act.
- Provides both in or out-of-network care.
- Access to a Traditional Health Care Flexible Spending Account (FSA) for tax savings on out-of-pocket health care expenses.

How to Find an In-Network Doctor

- Go to www.Anthem.com
- Click **Find Care then you can:**
  - Login for personalized search
  - Use Member ID for basic search or
- **Select a plan for basic search:**
  - Select **Medical Plan** or **Network**
  - Select **Georgia** (Non-Georgia residents must select Georgia)
  - Select **Medical** (Employer Sponsored)
  - Select the network **Blue Open Access POS**

Medical Benefits | Open Access Plus Plans (OAP) | Anthem

	$1,000 OAP		$2,500 OAP	
	In-Network Member Responsibility	**Out-of-Network** Member Responsibility	**In-Network** Member Responsibility	**Out-of-Network** Member Responsibility
Calendar Year Deductible (Individual/Family)	$1,000/$3,000	$3,000/$6,000	$2,500/$7,500	$7,500/$22,500
Coinsurance	20%	50%	20%	50%
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)	$4,500/$9,000	$13,700/$27,000	$5,500/$11,000	$21,450/$42,900
Preventive Care	0%	50% after deductible	0%	50% after deductible
Emergency Room	$150 copay; 20% coinsurance		$200 copay; 20% coinsurance	
Primary Care Physician (PCP)	$25 copay	50% after deductible	$30 copay	50% after deductible
Specialist	$50 copay	50% after deductible	$60 copay	50% after deductible
Virtual Visits Text Visits	First 12 visits free; then $25 copay $0 copay	50% after deductible	First 12 visits free; then $30 copay $0 copay	50% after deductible
Urgent Care	$60 copay	50% after deductible	$60 copay	50% after deductible
Inpatient Hospital Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery/Advanced Imaging at a Freestanding Facility	$150 copay; 20% coinsurance	50% after deductible	$200 copay; 20% coinsurance	50% after deductible
Outpatient Surgery/Advanced Imaging at a Hospital Setting	20% after deductible	50% after deductible	20% after deductible	50% after deductible
	Retail	**Mail Order**	**Retail**	**Mail Order**
Tier 1	$15	$15	$15	$15
Tier 2	$35	$70	$45	$90
Tier 3	$60	$180	$85	$255
Tier 4	20% up to $300	20% up to $300	20% up to $300	20% up to $300

Medical Benefits | HDHP| Anthem

What Is a High-Deductible Health Plan (HDHP)?

The term high-deductible health plan (HDHP) refers to a health insurance plan with a sizable **deductible** for medical expenses. An HDHP usually has a larger annual deductible than a typical health plan but charges lower monthly **premiums**. Plans fully cover routine preventive care.

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High-Deductible Health Plan (HDHP)

Key Features

- **Zero cost for employee only coverage.**
- Deductible must be met before copays kick in.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per member deductible and per member out-of-pocket maximum.
- Amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum.
- No one member will pay more than the per member deductible or per member out-of-pocket maximum.
- Your copays, coinsurance and deductible count toward your out-of-pocket amount(s).
- Co-pays apply after the deductible is met for Primary Care Physician, Specialist, Urgent care and Prescriptions.
- Free in-network preventive care
- Provides both in or out-of-network care.
- Access to Health Savings Account
- You may contribute additional amounts to your HSA (up to the statutory maximum) with pre-tax salary reductions.
- Access to a Limited Health Care Flexible Spending Account (FSA) for dental or vision expenses.

Converge Contributes!

Converge contributes to your Health Savings Account based on your election:

- **Employee** - $500
- **Employee + Spouse** - $750
- **Employee + Child(ren)** - $750
- **Family** - $1,000

Contributions are front loaded annually for current employees and prorated throughout the year for new hires.

How to Find an In-Network Doctor

- Go to www.Anthem.com
- Click **Find Care then you can:**
  - Login for personalized search
  - Use Member ID for basic search or
- **Select a plan for basic search:**
  - Select **Medical Plan** or **Network**
  - Select **Georgia** (Non-Georgia residents must select Georgia)
  - Select **Medical** (Employer Sponsored)
  - Select the network **Blue Open Access POS**

Medical Benefits | High-Deductible Health Plan (HDHP) | Anthem

	HDHP	
	In-Network Member Responsibility	**Out-of-Network** Member Responsibility
Annual Calendar Year Deductible (Individual/Family)	$4,500/$9,000	$13,500/$27,000
Coinsurance	0%	50%
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)	$6,550/$13,100	$19,650/$39,300
Preventive Care	0%	50% after deductible
Emergency Room	0% after deductible	
Primary Care Physician (PCP)	$30 copay after deductible	50% after deductible
Specialist	$60 copay after deductible	50% after deductible
Virtual & Text Visits	0% after deductible	50% after deductible
Urgent Care	$60 copay after deductible	50% after deductible
Inpatient Hospital Care	0% after deductible	50% after deductible
Outpatient Surgery/Advanced Imaging at a Freestanding Facility	0% after deductible	50% after deductible
Outpatient Surgery/Advanced Imaging at a Hospital setting	0% after deductible	50% after deductible
Pharmacy Deductible	Combined with Medical Deductible	
	Retail	**Mail Order**
Tier 1	$15 copay after deductible	$38 copay after deductible
Tier 2	$40 copay after deductible	$100 copay after deductible
Tier 3	$80 copay after deductible	$200 copay after deductible
Tier 4	25% up to $350 after deductible	25% up to $350 after deductible

Sydney Health | Anthem

Anthem Sydney Mobile App

Employees enrolled in the Anthem health plan can take advantage of Anthem's Sydney Health mobile app. This app provides quick access to your Anthem plan information — all in one place.

Check claims
- See what's covered and what you owe.

See benefits
- Check what your plan covers and how much you might pay.

Get your ID card
- Share, fax or email your ID card right from your device.

Find a doctor
- Look for doctors in your plan.

Get medicine
- Refill your prescriptions online.

Estimate costs
- Compare costs and quality for common procedures.

Manage health care accounts
- Pay or reimburse yourself for health care expenses.
- See your account balance anytime.

Primary Care Physician Virtual Care

Through the Sydney Health app you can also visit with a doctor at your convenience. The Sydney Health mobile app connects you to a team of doctors ready to help you on your time.

OAP Plan Participants Pay $0 Copay
HDHP participants 0% coinsurance after deductible is met.

There are two secure ways to find no- or low-cost care through our app:

Chat with a doctor 24/7 without an appointment
- Urgent care support for health issues, such as allergies, a cold, or the flu.
- New prescriptions for concerns such as a cough or a sinus infection.

Schedule a virtual primary care appointment
- Routine care, including wellness check-ins and prescription refills.
- Personalized care plans for chronic conditions, such as asthma or diabetes.

sydney

Get started with Sydney
Download the app today!

GET IT ON Google Play

Download on the App Store

You can also assess your symptoms with the Symptom Checker.

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

LiveHealth Online Doctor Visits | Anthem

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. You can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

LiveHealth Online – Telemedicine

See a board-certified doctor 24/7. You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose. It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue. To follow is a breakdown of the costs per plan:

$1,000 OAP
- First 12 visits free and then $25 copay
- Specialist Care $50 copay

$2,500 OAP
- First 12 visits free and then $30 copay
- Specialist care $60 copay

HDHP
- Primary Care Provider zero% coinsurance after deductible met
- Specialist $60 copay per visit after deductible is met

LiveHealth Online Psychology

Visit a licensed Psychologist or Therapist

Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more.

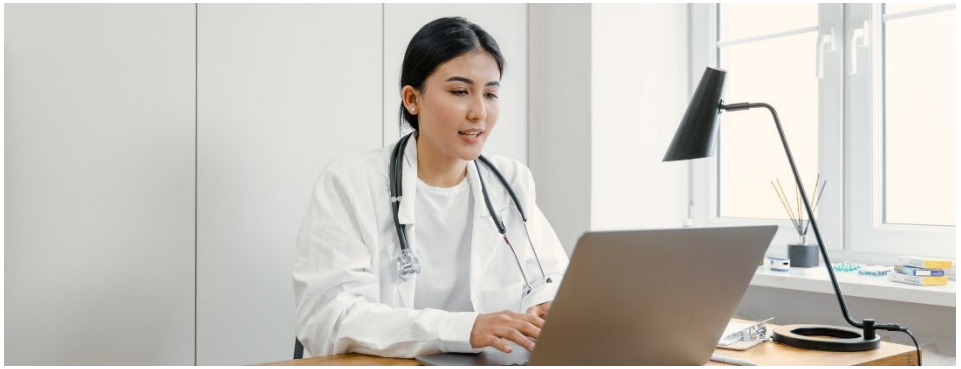
Consult a board-certified Psychiatrist

If you're over 18 years old, you can get medication support to help you manage a mental health condition.

Pricing for HDHP for Psychology (Non-HDHP follows office copay):
- $95 for session with a Psychologist
- $80 for a session with a licensed social worker/therapist
- $175 for initial visit with Psychiatry
- $75 for follow up visit with Psychiatry

LiveHealth Specialists

Schedule a visit with a board-certified Specialist to have a video visit with an Allergist, Sleep specialist or Dermatologist.
- Specialty cost share applies for each visit.



LiveHealth Online

Call **1-888-548-3432**
to schedule an appointment or log into livehealthonline.com for access to doctors, specialists, licensed therapists psychologists or psychiatrists.

Download the app on the **App Store** or **Google Play**.

Wellness | Anthem

Anthem Engagement 700 Healthy Rewards

Anthem Health Rewards offers you and your covered spouse or partner up to **$700** in rewards for taking part in Anthem's health and wellness programs. You will receive your rewards through electronic gift cards for select retailers. To access any of the following programs or to check the status of your progress, login to anthem.com or download the Sydney Health mobile app.

Preventive Care		
Annual Adult Wellness Exam or Well Woman Exam	Claims	$20
Cholesterol Test	Claims	$5
Colorectal Cancer Screening	Claims	$25
Flu Shot	Claims	$10
Mammogram	Claims	$25

Condition Management		
ConditionCare	Completion	$175
Diabetic Foot Exam	Claims	$20
Claims-Based Diabetic Lab Tests	Claims	$30
Future Moms	Completion	$125
Wellness Coach telephonic – Tobacco	Completion	$50
Wellness Coach telephonic – Weight	Completion	$50

Wellness		
Action Plans	Tracked	$25
Connect a Device	Tracked	$5
Emotional Wellness Resources Program Participation	Self-reported	$5
EAP Program Outreach	Self-reported	$5
Health Assessment	Tracked	$20
Log Into Website or App	Tracked	$5
Reading 5 Articles or Watching 5 Videos	Tracked	$5
Track Steps	Tracked	$80
Update Contact Information	Tracked	$15
Wellness Coach Digital	Tracked	$25

Pharmacy Benefits | Anthem

90-Day Pharmacy Fill

Anthem's 90-day retail pharmacy program offers you two ways to save on your long-term medications:

- 90-Day Retail prescription which must be filled at a CVS pharmacy.
- **Save time:** Receive a three-month supply of medication with free standard shipping through Anthem's Home Delivery pharmacy.

You can also get professional support: Call the 24-hour, toll-free number for home delivery at **1-833-203-1739** to speak with a registered pharmacist about your pharmacy questions or concerns.

Preventive Medication Savings

The IRS allows certain preventive medications to be covered at 100% under high-deductible health plans. You don't have to meet the deductible before these medications are covered in full.

To get these preventive drugs, including over-the-counter drugs or products:

- You must be the right age
- You need a prescription from your doctor
- Use your Anthem ID card to fill the prescription at your pharmacy

Reminder

Saving Money with GoodRx

GoodRx is a website and mobile app that tracks prescription drug prices and offers drug coupons in the United States. They check more than 75,000 pharmacies in the United States. No sign-up is required and there are no fees.

Ways to Save on Rx

- **Choose generic drugs** for you and your family to pay the lowest out-of-pocket cost.
- **Select drugs from Anthem's formulary** (preferred drugs) to pay less and maximize your plan's benefits.
- **Save by using 90-day prescription** fill at participating 90-day retail pharmacies or Home Delivery pharmacy.
- **Log in to Anthem's Pharmacy Cost Comparison Tools** at Anthem.com or the Sydney app and compare costs for 30-day retail vs. 90-day retail vs. home delivery for the lowest cost to fill your medication.

California Residents Medical Benefits | HMO | Kaiser

A health managed network or HMO refers to a health insurance plan with only one network. Benefits include a wide range of programs with most offered at little or no additional cost and the Kaiser HMO network is extensive in **California**. California residents still have the option of choosing from the three offered Anthem plans, in addition to Kaiser.

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Health Managed Network (HMO)

Key Features

- Low cost for employee only coverage.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per member deductible and per member out-of-pocket maximum.
- Amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum.
- No one member will pay more than the per member deductible or per member out-of-pocket maximum.
- Your copays, coinsurance and deductible count toward your out-of-pocket amount(s).
- Co-pays apply after the deductible is met for Primary Care Physician, Specialist, Urgent care and Prescriptions.
- Free in-network preventive care per the Affordable Care Act guidelines.
- Provides both in-network care.
- Access to a Health Care Flexible Spending Account (FSA) for dental or vision expenses.

Register on kp.org

Your connection to great health is **kp.org**, where you can manage your health care anytime, anywhere.

You can email your Kaiser Permanente doctor's office with non-urgent questions, schedule and cancel routine appointments and view most lab test results.

Once you get your Kaiser Permanente ID card, getting started is easy at **kp.org/register**.

California Residents Medical Benefits | Kaiser

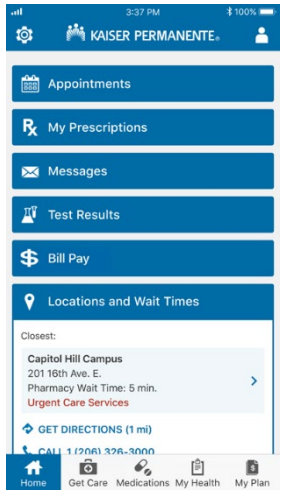
	HMO
	In-Network Member Responsibility
Calendar Year Deductible (Individual/Family)	$1,000/$2,000
Coinsurance	20%
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)	$3,000/$6,000
Preventive Care	0%
Emergency Room	20% after deductible
Primary Care Physician (PCP)	$20 copay
Specialist	$20 copay
Telehealth	$0 copay
Urgent Care	$20 copay
Inpatient Hospital Care	20% after deductible
Outpatient Hospital Care	20% after deductible
Pharmacy Deductible	None
	Retail
Tier 1	$10
Tier 2	$30
Tier 3	20% up to $250
Mail Order	$20/$60/N/A

Kaiser App

Use the convenient features of My Health Manager right from your smartphone or other mobile devices.

- Email your doctor's office
- View most test results
- Schedule or cancel routine appointments
- Refill most prescriptions
- View past visits

Download with **apple store** or **google play**.



Choose Your Doctor – and Change Anytime

Connecting you with a doctor who suits your needs is our top priority. At **kp.org/searchdoctors**, you can browse our physician bios and choose one based on what's important to you — like the specialty care you need or languages you speak.

Search locations in your area at **kp.org/kpfacilities**.

Get Prescriptions

It's easy to get your prescriptions. After you join, just call us or go online, and we'll help you transition your prescriptions to the Kaiser Permanente pharmacy of your choice.

You can also order most refills online at **kp.org/refill** and have them shipped to your home at no charge for shipping.

ChooseHealthy Program

Healthy Living Classes & Programs

Our health classes can help you:

- Manage chronic conditions like diabetes and asthma
- Eat better
- Keep your kids healthy
- Lose weight (Some classes may require a fee.)
- Access to ClassPass
  - Unlimited on-demand video workouts
  - Livestreams of top-rated fitness classes
    - Real-time online classes from top studios and instructors from around the world. Classes include boxing, Pilates, dance, yoga, HIIT, barre, boot camp, prenatal and more.
- In-person gym classes
  - Reduced rates for classes at some of the top gyms and fitness studios in the area. ClassPass partners with 30,000 gyms and studios around the world.

Wellness Coaching by Phone

Get the extra support you need to lose weight, quit tobacco and more by working with a wellness coach by phone. Information about the coaching services you receive will be included in your electronic health record and be accessible by your Kaiser Permanente care team.

kp.org/wellnesscoach

How to Sign Up

Go to kp.org/choosehealthy.

1. Choose your region.
2. Click the “ChooseHealthy” link.
3. Click “Find a Provider.”

Or call 1-877-335-2746 for help.

Member Discounts

Get reduced rates on a variety of health-related products and services through The ChooseHealthy program. These include:

- **Acupuncture** — **Up to 25% off** a contracted acupuncturist’s regular rates
- **Active&Fit Direct** — members pay **$25 per month** (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers
- **Chiropractic care** — **Up to 25% off** a contracted chiropractor’s regular rates
- **Massage therapy** — **Up to 25% off** a contracted massage therapist’s regular rates

HSA / FSA / COMMUTER

Health Savings Account (HSA) | WealthCare Saver

What is a Health Savings Account (HSA)?

This is a personal bank account which is established through WealthCare Saver when you enroll in the Anthem High-Deductible Health Plan (HDHP).

An HSA provides a triple tax advantage:

- **Tax-free contributions**
- **Tax-free growth on earnings**
- **Tax-free distributions for qualified medical expenses.**

Your individual contributions are tax free up to an annual maximum set by the IRS for 2023.

- **Individual** - $3,850
- **Family** - $7,750
- If you are age **55** or older you also qualify for an extra $1,000

- Easy to use debit card
- The account is owned by you and goes with you if you change plans or your employment ceases.
- The contributions rollover year to year.
- Once you meet a minimum threshold ($1,000) you can choose to move money to an investment account where you can choose from a variety of mutual funds. Note – there is a $2.25 monthly fee.
- Contributions and withdrawals from the HSA are reportable on your annual income tax returns; it is important to retain receipts.

Who is Eligible to Contribute to an HSA?

To cover yourself or a family member under an enrolled HSA, you must be in a qualified High-Deductible Health Plan (HDHP) and **CANNOT**:

- Be enrolled in TriCare, Medicare or Medicaid
- Be able to be claimed as a dependent under someone else for tax purposes
- Be covered by a traditional-style (PPO, OAP, HMO, etc.) health plan
- Participate in a Health Care Flexible Spending Account (FSA) plan

HSA Coverage for Adult Children Under Age 26

While the Patient Protection and Affordable Care Act allows parents to add their adult children up to age 26 to their health plans, the IRS has not changed its definition of a dependent for Health Savings Accounts. If account holders cannot claim a child as a dependent on their tax returns, then they cannot spend HSA dollars on services provided to that child. According to the IRS definition, a dependent is a qualifying child who:

- Has the same principal place of abode as the covered employee for more than one-half of taxable year.
- Has not provided over one-half of their own support during taxable year.
- Is not yet age 19 (or not yet age 24 if a student) at the end of the tax year or is permanently and totally disabled.

Flexible Spending Account (FSA) | WEX Health

Traditional Health Care Flexible Spending Account (FSA)

A Health Care FSA allows you to set aside a portion of your earnings on a pre-tax basis through payroll deductions to pay for qualified health care expenses.

- The IRS regulates how much you can contribute to FSAs each calendar year:
- **$3,050 for Health Care FSAs and Limited Health Care FSAs.**
- This type of FSA is available to employees who enroll in one of Anthem's OAP plans or the Kaiser HMO plan.
- You can also sign up for this FSA if you **do not** take either the OAP or Kaiser plan.
- If you or your spouse contribute to an HSA, you are **not eligible** to elect this FSA, but you can elect a Limited FSA.
- You must actively enroll in an FSA each year to participate.
- You can only make changes to your FSA contributions during the year if you have a qualifying life event.

Use-It-or-Lose-It

You have until March 31, 2024 to submit claims incurred in 2023 for reimbursement under the 2023 WEX Health Inc. FSA plans. Any balance over the $610 rollover will be forfeited under the IRS "use-it-or-lose-it" provision.

Once your employment ends, you won't be able to spend your FSA funds, but you do have 90-days to submit claims for FSA-eligible expenses that you incurred while employed and during the current plan year.

Limited Purpose Flexible Spending Account

- The Limited Purpose Health Care FSA is designed to use in conjunction with the Anthem High-Deductible Health Plan.
- Eligible expenses from a Limited Purpose FSA only include dental and vision expenses.
- If you are moving from an OAP/Traditional FSA plan, the Health Care FSA must be a zero balance as of December 31, 2023.
- Any unused funds up to $610 can be rolled over to a Limited Purpose FSA.

Download

WEX Health Inc.

The free WEX Health Inc. mobile app allows you to check account balances, upload receipts or contact customer service.

Download on the **App Store** or **Google Play**.

Flexible Spending Account (FSA) Debit Card

If you are enrolling in a Traditional Health Care FSA or a Limited FSA for the first time in 2023, you'll receive one debit card to use for eligible health care expenses starting January 1. You are not required to have a personal identification number (PIN), simply choose the "credit' option when using your card. Or you can call the number provided on the card to set up a PIN.

- **WEX Health Inc.** will suspend use of your debit card if requested receipts are not received within the required time frame of 72 days, which may result in a tax liability to you.
- Didn't use your debit card to pay for an eligible expense? Download the claim form **wexinc.com** for reimbursement.
- You can also submit claims through the WEX Health Inc. mobile application. Simply take a photo with your smartphone or tablet and upload the image for processing. You will be reimbursed by check or direct deposit within approximately 7 to 10 business days of submitting your form.

FSA Calculator

- Find out how an FSA can help you pay less tax and increase your net take-home pay with the Wex Health Inc. FSA calculator.
- Go to www.irs.gov/publications/p502 for a list of eligible expenses.

Dependent Care FSA & Commuter Benefit

Dependent Care FSA

The Dependent Care FSA allows you to set aside up to **$5,000 annually** with pre-tax payroll deductions to reimburse yourself for eligible expenses for childcare or the care of a disabled spouse or elderly parent. Examples of eligible expenses include child day care centers, before-school or after-school costs, adult day care centers or summer day camps that allow you (and your spouse, if married) to work or look for work.

- This option is available to all employees, even if you do not enroll in other coverage with Converge.
- You can participate in both the Health Care FSA and the Dependent Care FSA at the same time, but you cannot use funds in one to pay for expenses in the other.

Eligible dependents are:

- Your children under age 13 (If your dependent child will turn age 13 in 2023, this will disqualify you from receiving FSA funds from age 13 and forward, which means you may lose your FSA contribution funds). **Please calculate your funds appropriately.**
- Your physically or mentally incapacitated spouse or children over age 13.
- Any other person residing in your household and considered a dependent for tax purposes and who is physically or mentally incapable of self-care, regardless of age.

Use-It-or-Lose-It

You have until June 30, 2024 to submit claims incurred in 2023 for reimbursement under the 2023 WEX Health Inc. Dependent Care plan. Any balance after that date will be forfeited under the IRS "use-it-or-lose-it" provision.

Once your employment ends, you won't be able to spend your FSA funds, but you do have 90-days to submit claims for FSA-eligible expenses that you incurred while employed and during the current plan year.

Getting Reimbursed

You may use your FSA debit card for dependent care expenses at providers who only provide childcare, as the debit card will recognize the Merchant Category Code.

You may also get reimbursed for eligible dependent care expenses by completing a claim form at **wexinc.com**.

Send your completed claim form and receipt(s) to WEX Health Inc. at the address or fax number listed on the form. You will receive reimbursement by check (or direct deposit if you elect this option) within approximately 7 to 10 business days.

Transportation/Commuter Benefit

Pre-Tax Commuter Card

A Pre-tax Commuter Benefit Spending Account Card also offers you a convenient, hassle-free, money-saving benefit you'll appreciate every time you commute.

With the Pre-tax Commuter Card, you can enroll purchase transportation passes online with home delivery and pay parking vendors directly. This avoids the hassle of submitting receipts for substantiation or reimbursement.

- The Transportation Spending Account is used to pay for eligible mass transit or vanpool expenses associated with travel to and from work, including bus, train, or subway. There is a monthly maximum election of $280.
- The Parking Spending Account is used to pay for eligible parking expenses either near your place of employment or at a location from which you commute to via mass transit or vanpool. There is a monthly maximum election of $280.

Tax-Free Savings Account Overview

	Health Savings Account	Health Care FSA	Limited Health Care FSA	Dependent Care FSA	Transit & Parking
Anyone Can Enroll	**No** – only employees who elect the Anthem HDHP plan are eligible to enroll.	**No** – If you and/or your spouse are contributing to an HSA account you are **not** eligible.	**No** – only employees who enroll in a HDHP are eligible to enroll.	**Yes** – You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.	**Yes**
Tax-Advantage Account	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Balance Rolls Over Each Year	**Yes**	Up to $610 annually – use-it-or-lose-it.	Up to $610 annually – use-it-or-lose-it.	**No** – use-it-or-lose-it	**Yes**
Termination Rules	HSA funds remain available even after termination.	90-days to submit claims for FSA-eligible expenses incurred during the current plan year.	90-days to submit claims for FSA-eligible expenses incurred during the current plan year.	90-days to submit claims for FSA-eligible expenses incurred during the current plan year.	Funds are no longer available once you terminate employment.
Accrues Interest	**Yes**	**No**	**No**	**No**	**No**
Eligible Expenses Include	Medical/Rx, Dental, and Vision – including items not covered under plan, like LASIK. (See IRS 213d for list of covered items).	Medical/Rx, Dental, and Vision – including items not covered under plan, like LASIK. (See IRS 213d for list of covered items).	Only Dental, Vision and Preventive Medical care expenses until the medical deductible is met.	Expenses incurred while providing care for dependents, including elders, like expenses for babysitting or summer day camp – so long as they have a business Tax ID.	Funds roll over month to month.
Annual Contribution Limit	$3,850 for Employee Only; $7,750 for all other coverage tiers (both IRS limits include Converge's funding); $1,000 additional if age 55 or older.	$3,050	$3,050	$5,000 ($2,500 if married filing separately).	The IRS sets the maximum dollar amount you can set aside each month as a part of your commuter benefit. **Transit** – $280 monthly **Parking** – $280 monthly
Who Can Contribute?	You (or anyone on your behalf) and Converge. Converge funds HSAs with $500 for **Employee** coverage, $750 for **Employee + Spouse/Child(ren)** and $1,000 for **Family**.	You	You	You	You
Investment Options	**Yes** – once the balance reaches $1,000.	**No**	**No**	**No**	**No**

DENTAL & VISION

Dental Benefits | Anthem

Regular preventive care visits to your dentist can help protect your overall health. Studies have linked gum disease to problems in other areas of the body. In fact, studies by the Centers for Disease Control and Prevention show there may be a link between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births.

Converge offers a choice of two dental plans with Anthem that cover a full range of services including orthodontia. You have the choice of the Core Plan and the Buy-Up Plan, and both plans have the same network of dentists.

The key difference between the two plan options is how they work when you visit an out-of-network dental provider.

- The Core Plan reimburses based on a specific fee schedule.
- The Buy-Up Plan reimburses up to the 90th percentile of UCR charges (Usual, Customary & Reasonable), which means that 90% of the dentists in a given area charge that fee or less for a particular service. This results in a lower out-of-pocket cost to you than the out-of-network fee schedule under the Core Plan.

Plan Features	Core Plan Member Responsibility	Buy-Up Plan Member Responsibility
Calendar Year Benefit Maximum	$2,000	$2,000
Calendar Year Deductible	$0	**Individual:** $50 **Family:** $150
Preventive & Diagnostic Care Oral Exams, Routine Cleanings, X-Rays	0%	0%
Basic Restorative Care Fillings, Root Canal Therapy, Oral Surgery	20%	20% after deductible
Major Restorative Care Crowns, Dentures, Bridges	50%	50% after deductible
Orthodontia (Child & Adult)	50%	50%
Orthodontics Lifetime Benefit Maximum per Member	$2,000	$2,000

Dental

- Go to www.Anthem.com
- Click **Find Care** then you can:
  - Login for personalized search
  - Use Member ID for basic search or
- Or simply select a plan for **basic search:**
  - Select **Dental Plan** or **Network**
  - Select **Georgia**
  - Select **Dental**
  - Select the network **Dental Complete**

Vision Benefits | Anthem

Even if you can see well, regular eye exams help keep your eyes healthy and catch other health conditions early. Our Anthem vision benefit through EyeMed covers comprehensive eye exams, glasses, and contacts.

If you choose, you can receive covered benefits outside of the Blue View Vision network. Simply pay in full at the time of service, obtain an itemized receipt and file a claim for reimbursement up to your maximum out-of-network allowance.

Locate a provider in your area at www.anthem.com/find-care

Plan Features	In-Network Member Responsibility	Out-of-Network Member Responsibility
Eye Exam (once every calendar year)	$10 copay	Reimbursed up to $42
Frames Benefit (once every two calendar years)	$150 allowance; 20% off amount over your allowance	Reimbursed up to $45
Lenses (every 12 months) Single Vision, Bifocal, Trifocal, and Lenticular	$20 Copay	Reimbursed up to $40 – $125
Contacts (in lieu of glasses; once every calendar year)	$150 allowance for contacts; Medically necessary covered in full	Reimbursed up to $105; $210 for medically necessary
Lens Options		50% after deductible
Scratch-Resistant Coating	$0	No allowance when obtained out-of-network
Standard Lenses	$55	
Premium Progressive Lenses	$85 - $175	

Vision

- Go to www.Anthem.com
- Click **Find Care** then you can:
  1. Login for personalized search
  2. Use Member ID for basic search
  3. Or simply select a plan for basic search:
     - Select **Vision Plan** or **Network**
     - Select **Georgia**
     - Select **Vision**
     - Select the network **Blue View Vision**

WHAT YOU PAY

Semi-Monthly Employee Contributions | Salary

Medical	$2,500	$1,000	HDHP	Kaiser HMO California Resident Only
Employee Only	$50.00	$100.00	$0.00	$25.00
Employee + Spouse	$235.41	$293.77	$76.31	$62.91
Employee + Child(ren)	$179.31	$233.50	$31.57	$19.13
Family	$340.70	$425.47	$109.64	$90.18

Dental	Core	Buy-Up
Employee Only	$5.75	$6.47
Employee + Spouse	$13.29	$15.64
Employee + Child(ren)	$12.95	$15.12
Family	$20.84	$24.28

Vision	Anthem
Employee Only	$3.68
Employee + Spouse	$7.37
Employee + Child(ren)	$6.24
Family	$10.29

Detailed supplemental and worksite summaries and rates are available in Paycom.

Bi-Weekly Employee Contributions | Hourly

Medical	$2,500	$1,000	HDHP	Kaiser HMO California Resident Only
Employee Only	$46.15	$92.31	$0.00	$23.08
Employee + Spouse	$217.30	$271.17	$70.44	$58.07
Employee + Child(ren)	$165.51	$215.53	$29.14	$17.66
Family	$314.49	$392.74	$101.20	$83.24

Dental	Core	Buy-Up
Employee Only	$5.31	$5.97
Employee + Spouse	$12.27	$14.44
Employee + Child(ren)	$11.95	$13.96
Family	$19.24	$22.41

Vision	Anthem
Employee Only	$3.40
Employee + Spouse	$6.80
Employee + Child(ren)	$5.76
Family	$9.50

Detailed supplemental and worksite summaries and rates are available in Paycom.

LIFE & DISABILITY BENEFITS

Life Insurance | Anthem

Basic Life and Accidental Death and Dismemberment (AD&D)

Converge Technology provides employer paid Basic Life and Accidental Death and Dismemberment insurance to provide coverage for employees in the amount of 1.5x annual earnings up to $400,000.

Any pre-tax Life insurance provided by Converge in excess of $50,000 is subject to annual taxation.

Supplemental Life

Employees may also purchase additional life insurance protection for themselves, their spouse and/or dependent children. The cost of the coverage is based on the age of the employee and the amount of coverage elected. New Hires can elect up to the guarantee issue amount for themselves and their spouses. All others will be required to submit Evidence of Insurability (EOI) and be approved for a new election or an increase in coverage.

Employee
Employees may elect Supplemental Life in increments of $10,000 up to a maximum of $500,000.
Guarantee issue amount of $200,000.

Spouse
Employees may elect coverage on their spouse in increments of $5,000 up to a maximum of $100,000.
Guarantee issue amount of $50,000.

Child(ren)
Coverage is available on children in amounts of $1,000, $2,000, $4,000, $5,000 or $10,000.

Note: Employees must participate in the Supplemental Term Life Plan in order to elect spouse or child(ren) coverage.

Disability Coverage | Anthem

Employer Paid

Short-Term Disability

Short-Term Disability insurance pays a weekly benefit for a covered injury, sickness or maternity resulting in your inability to perform your duties at work.

Short-Term Disability (STD)	
Weekly Benefit	60%
Elimination Period (Accident and Sickness)	14 Days
Maximum Benefit Duration	11 Weeks
Maximum Weekly Benefit	$1,200

Long-Term Disability

In the event that you are still disabled when your Short-Term Disability coverage ends, your Long-Term Disability coverage will pay you a monthly benefit. The benefit will be payable for as long as you are disabled up to Social Security Normal Retirement Age. Benefits may be reduced by other income benefits and disability earnings.

Long-Term Disability (LTD)	
Income Replacement %	60% of monthly salary including commissions and bonuses up to $15,000 of benefit per month
Elimination Period	90 days
Maximum Benefit Duration	To Social Security Normal Retirement Age

Long-Term Disability Tax Choice | Anthem

Long-Term Disability Tax Choice An Important Decision.

Employees have the option to avoid paying taxes on the Long-Term Disability benefits paid if they choose to be taxed on the employer paid premium. Your taxable portion will be included in your 2023 W-2. If you elect to be taxed on the premium that Converge pays on your behalf and subsequently become disabled in that plan year, all Long-Term Disability benefits paid to you while out on disability will be tax-free.

Your election to have the value of your employer paid premium for Long-Term Disability coverage included on your W-2 as taxable income must be made prior to the beginning of the plan year in which the election becomes effective. The election is irrevocable once the plan year begins. You will be offered the option of making a change annually per IRS regulations.

If you elect not to include the value of the employer paid Long-Term Disability benefit on your W-2, any benefits paid to you will be considered taxable income for the duration of your disability.

The Chart Below Illustrates the Two Options ($65,000 salary)

You pay a minimal amount of tax throughout the year for your portion of the LTD premium to make your disability benefit **tax-free.**

OR

Converge pays all the taxes on the premium and, if you become disabled, the benefit would be **taxed.**

	Electing Tax Choice	Not Electing Tax Choice
Gross Monthly Benefit	$5,416.67	$5,416.67
Taxes (25% tax bracket)	N/A	$1,354.17
Net Monthly Benefit	$5,416.67	$4,062.50
Net Annual Benefit	$65,000	$48,750
Annual Employee imputed income with tax Assumptions $5,416.67/100 x $0.29 x 12 months 25% tax bracket	$188.50	$0.00

ADDITIONAL BENEFITS & RESOURCES

Carrot

We partner with Carrot Fertility to bring you inclusive, global fertility healthcare and family-forming benefits. Carrot plans support all fertility and family-forming journeys, including pre-pregnancy care, adoption, donor assisted options such as using a gestational carrier and fertility health exploration including testing and menopause or low testosterone support.

Converge is providing a $2,000 stipend that can be used towards eligible fertility and family building services. You must be enrolled one of our medical plans to be eligible.

Covered service and benefits include:

Lab Testing	Fertility Tracking Wearables	Adoption	Peri-menopause
Diagnostic Procedures	IVF and IUI	Surrogacy	Menopause
Sperm analysis kits	Fertility Medications	Doulas	Low Testosterone

Access to 3,800+ Clinics

- Telehealth support, at-home testing, and advanced wearables.
- Spouses and partners are included in membership.

Global Provider Network

- With 6,100+ clinics and agencies around the world, employees get care from providers that meet strict clinical and regulatory qualifications.

Carrot Card

- You can access your benefit and pay for services, without the stress of out-of-pocket payments.

Voluntary Supplemental Plans | Anthem

Voluntary Accident Insurance*

100% Employee Paid

Group Accident Insurance can help prepare you and your family for the financial hardship that can be encountered when you experience an accident. Accident Insurance will pay out, directly to you, money based on a set amount per procedure or service received. Whether you experience an accident at home or at work, this benefit allows you to receive funds to help pay for medical bills, replace income while you may be away from work, or help cover the mortgage or other bills. Accident Insurance is not medical insurance but is meant to help offset any costs associated with an accident.

Voluntary Hospital Indemnity Plan

100% Employee Paid

A hospital stay can be expensive and can happen at any time. Even with medical coverage, out-of-pocket expenses such as deductible costs, rehabilitation, and transportation can add up quickly. Prepare for the unexpected with a Hospital Indemnity policy (post-tax). It provides a fixed benefit amount to help cover expenses, and you can decide how to use the money.

Voluntary Critical Illness with Cancer Plan*

100% Employee Paid

Group Critical Illness provides a financial cushion with a lump-sum benefit payable if diagnosed with a covered critical illness. This includes: heart attack, stroke, invasive cancer, major organ transplant and neurological conditions such as advanced Alzheimer's and advanced Parkinson's.

As part of your Anthem Critical Illness plan, you earn a $50 health screening benefit when you get preventive tests such as mammograms, colonoscopies or fasting blood glucose tests.

**Note: Covered accidents or illness must occur after the effective date of coverage*

Anthem can send you email notifications when a medical claim is eligible for submission. You can opt in to receive an auto-notification via e-mail.

- To opt in to receive this email auto-notification:
  - Create a member account at anthem.com.
  - Under *Profile*, choose **Plan Notifications**.
  - Under *Go Paperless*, select **ON**.
  - Check the box by **Status Updates** for email.
  - Enter your email address.

Employee Assistance Program (EAP) | AnthemEAP

Contact Information

24/7/365

800-865-1044

or

anthemEAP.com

Company Code: **Converge**

Online tools to Help with Life's Issues

The AnthemEAP website has tools to help with life's challenges, such as:

- Creating a will
- Parenting
- Aging
- Healthy living
- Household support
- Referrals
- Funeral planning

AnthemEAP

Our Employee Assistance Program (EAP) is designed to offer you support with mental, financial, physical and emotional wellness, so you stay healthy at work and home. It provides you and your family members with a no-cost, confidential and user-friendly resource for life management concerns.

Counseling by Phone, Face-to-Face, or Video Chat

If you're feeling stressed, worried, or going through a tough time, you may want someone to talk to. You and your household family members can call Resource Advisor anytime, 24/7, and talk with a licensed counselor:

- **In-person**: You can call to set up to four face-to-face sessions and then schedule appointments directly with your counselor.

Counseling
- Up to 4 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services

Legal Consultation
- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online

Financial Consultation
- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online

ID Recovery
- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations

Emotional Well-being Resources
- Digital tools to improve emotional well-being
- Team up with an experienced clinical coach
- Practice mindfulness on the go

Dependent Care and Daily Living Resources
- Online information about childcare, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

Other anthemEAP.com Resources
- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

Crisis Consultation
- Toll-free emergency number; 24/7 support
- Online critical event support during crises

Parental Leave

Types of Parental Leave

- 8 weeks of company-paid leave for mothers recovering from childbirth
- 2 weeks of company-paid leave for parents who did not give birth to the child
- 8 weeks of company-paid leave for parents to bond with a new child through adoption

Who to Contact

If you are an expecting parent, email benefits@convergetp.com a few months before your due date to plan ahead.

Additional Perks

Verizon Corporate Plan

Save big with the best network!

We are officially offering participation in the new Converge Verizon Business Plan to all Converge employees and their families. See plan details below.

- Converge Verizon Business plan available for you and your family members.
- $50 per month/phone line (deducted via payroll; Converge covers employee line).
- Unlimited Talk Text, Data ; 2-year contract.
- $50 per month cell phone allowance for those employees not enrolled on the Converge corporate cell phone plan.

Contact benefits@convergetp.com for up-to-date details on discounts and offers for 2023.

Internet Allowance

$100 per month internet allowance for all full-time Converge employees.

Generali Global Assistance

Help While Travelling

- Medical referrals and case reviews
- Medical evacuation/return home
- Traveling companion assistance
- A hospital visit by a family member/friend
- Bringing your remains home if you pass away
- Emergency travel arrangements, cash, legal help and bail
- Interpretation/translations

Before You Travel

- Visa requirements
- Passports and immunization requirements
- Foreign exchange rates
- Travel advisories (State Department warnings)

Contact

United States and Canada: 866-295-4890
Everywhere else: 202-296-7482
Text: +1-609-334-0807

Need Help with Your Benefits?

Our insurance broker, NFP, provides claim assistance services for your medical, dental, vision, life and disability plans. Deanna Waid is your dedicated advocate. Here are a few examples of how she can help:

- Explanation of Benefits review
- Advice on denials and appeals processes
- Locate in-network providers
- Triage urgent procedures
- Investigate medical bills
- Resolve claims and billing issues
- Explain coverage and benefits
- Support for the whole family
- Coordinate second opinions
- Direct carrier contacts

Call Deanna Waid

404-814-6069
deanna.waid@nfp.com

FINANCIAL WELLNESS

401(k) Plan | T. Rowe Price

401(k) New Hire Enrollment and Eligibility

- All full-time and part-time new hires will be auto-enrolled in the Converge 401(k) Plan with a **3% pre-tax deferral rate**.
- The eligibility requirement is age 18, 1 month of employment, and entry on the first day of the following month. For example, if an employee is hired on August 5th, they would have 1 month of employment on September 5th and then would be eligible to enter the plan on October 1st (first day of the following month).
- Employees will have the opportunity to opt-out or change your deferral rate prior to the enrollment date anytime on the **T. Rowe Price website**.
- You will receive information directly from T. Rowe Price via email and mail regarding how to login.
- The Converge 401k plan offers Pre-Tax 401(k) contributions as well as Roth 401(k) contributions.

IRS Pre-Tax and Roth Contribution Limits for 2023

- $22,500
- $7,500 Catch-up Contribution for Employees over age 50

The Converge 401(k) plan is not subject to an open enrollment period; employees can enroll in the 401(k) plan or change your deferral elections at anytime on the T. Rowe Price website.

For all 401(k) questions, please reach out to FinancialWellness@convergetp.com

401(k) Plan Discretionary Match

Converge is proud to offer a discretionary matching contribution to your retirement plan! Converge is committed to investing in your future and helping your savings by adding this employer contribution to your 401k account.

How Does the Converge 401(k) Match Work?

If you participate in the Converge 401(k) plan and contribute at least 1% of your earnings, the company will contribute additional money to your account during the **first quarter of the following year**. Save at least 6% to take full advantage of this benefit. The annual match is discretionary and is dependent on company performance.

Here's How it Works

For every dollar you contribute, up to 6% of your pay, Converge will add $0.25 to your account. Not sure what that means to you? Here are a couple of examples:

- A Converge employee earns $50,000 annually and contributes 3% to the Plan. On an annual basis, they contribute $1,500 on their own and Converge adds a $375 matching contribution.
- Another Converge employee also earns $50,000 annually but contributes the full 6% to the Plan. On an annual basis, they contribute $3,000 on their own and Converge adds a $750 matching contribution.

For all 401(k) questions, please reach out to FinancialWellness@convergetp.com

Employee Share Purchase Plan (ESPP) | Computershare

At Converge, we want employees to have the opportunity to be owners! Through our Employee Share Purchase plan, all full-time employees are eligible to participate immediately.

- Employees may elect to purchase up to $25,000 of stock per year.
- The elected per pay period amount is payroll deducted each check.
- The Elected amount can only be changed **once per calendar year.**
- Converge will contribute an additional **match of 20%** of the employee's share purchase.
- The Converge 20% match is a taxable benefit that will be processed within payroll each month.
- Computershare administers the ESPP; employee enrollment is completed on the Computershare site.
- Contributions are purchased off of the Toronto Stock Exchange.
- Converge covers the fees associated with administering the ESPP plan.
- Employee purchased shares can be sold at any time, subject to blackout periods.
- **Enrollment is 100% voluntary. Employees are not required to opt-out of the ESPP if you choose not to participate. ESPP is not subject to an open enrollment period.**

Enrollment Timeline

- **New Hires:** Employees will receive two welcome emails from Computershare, during the month following their date, that will provide a Global Identifier & PIN for logging in to the Computershare site.
- Due to the administrative process timeline, it may take up to 2 pay periods for new enrollments to be reflected in payroll.
- When enrolling, make sure to elect your per pay contribution ***Not annual*.**

For all ESPP questions, please reach out to FinancialWellness@convergetp.com

ADDITIONAL INFORMATION

Contact Information

Service	Provider	Phone or Email	Website
Client Advocacy	NFP	**Deanna Waid** 404-814-6069 deanna.waid@nfp.com	N/A
Medical	Anthem	1-855-397-9267 – All Other Members 1-844-274-5201 – HDHP Members	www.anthem.com
Medical – California Residents ONLY	Kaiser	1-800-464-4000	www.kp.org
Dental	Anthem	1-844-729-1567	www.anthem.com
Vision	Anthem	1-866-723-0515	www.anthem.com
Life and AD&D Insurance	Anthem	1-800-552-2137	www.anthem.com
Short-Term Disability	Anthem	1-800-232-0113	www.anthem.com
Long-Term Disability	Anthem	1-800-232-0113	www.anthem.com
Flexible Spending Account	WEX Health Inc.	1-866-451-3399	www.wexinc.com
Health Savings Account	Anthem	1-866-451-3399	www.anthem.com
Accident/Critical Illness/Hospital Indemnity	Anthem	1-888-828-2432	www.anthem.com
Employee Assistance Program	AnthemEAP	1-800-865-1044	www.anthemEAP.com Company Code Converge
Travel Assistance	Anthem	U.S./Canada 1-866-295-4890 Other locations 1-202-296-7482	www.anthem.com
Converge Benefits	Converge	benefits@convergetp.com	N/A
Converge Wellness	Converge	wellness@convergetp.com	N/A
Converge ESPP	Converge	espp@convergetp.com	N/A
401(k)	Converge	financialwellness@convergetp.com	N/A

Benefits At-A-Glance

Benefits	Premium Cost	Description
Medical Insurance OAP & HMO	Cost is shared by Converge and Employee	Medical and prescription coverage. Employees pay a portion of the premiums before taxes.
Medical Insurance HDHP	Cost is shared by Converge and Employee	Medical and prescription coverage. Employees pay a portion of the premiums before taxes.
Health Savings Account (HSA)	Employee/Employer contributions	A Health Savings Account is automatically opened once you enroll in the HDHP to help save on qualified medical expenses. Employees can contribute pre-tax into this account and Converge provides an employer contribution. These funds can be used to pay for medical, dental and vision expense.
Dental Insurance Core and Buy-Up	Cost is shared by Converge and Employee	Dental coverage including preventive, basic and major treatment and orthodontia. Must choose between the plans. See plan details for difference between plans.
Vision Benefits	Employee pays premium	Vision coverage; Employee pays 100% of premium, before taxes, for self or family coverage.
Flexible Spending Account (Healthcare, Limited and Dependent)	Employee contributions	Flexible spending accounts are reimbursement accounts that allow you to set aside pretax dollars each calendar year to cover out-of-pocket healthcare and dependent care expenses incurred during the year.
Commuter Benefit	Employee contributions	Pre-tax benefit for work-related transit and parking expenses.
LiveHealth Online - Anthem	Included in your medical plan	First 12 visits are available at no cost, then PCP copay if you are enrolled in the OAP plans. HDHP participants pay nothing once they've met their annual deductible.
Basic Life and AD&D Insurance	Employer paid 100%	1.5 times your annual earnings to $400,000.
Supplemental Life	Employee paid	Increments of $10,000 to a maximum of $500,000.
Spouse Life	Employee paid	Increments of $5,000 to a maximum of $100,000.
Dependent Life	Employee paid	Amounts of $1,000, $2,000, $4,000, $5,000 or $10,000.
Voluntary Supplemental Plans	Employee paid	A supplemental health insurance plan provides extra protection that helps pay for covered accident, hospital visits and unexpected critical illnesses.
Short-Term Disability	Employer paid 100%	Income protection for non-work related accident or illness. Begins 14 days after qualifying accident or sickness, lasts up to 11 week and pays 60% of your weekly earnings up to $1,200 per week.
Long-Term Disability	Employer paid 100%	Provides 60% of your monthly income up to $15,000. If you become disabled before age 62, Long-Term Disability benefits may continue until age 65 or to the Social Security Normal Retirement Age (SSNRA).
Travel Assistance	Employer paid 100%	Offers help before and during your trip when traveling more than 100 miles from home, including: currency exchange information, travel advisories, credit card and passport replacement, missing bag and emergency cash coordination etc.
Employee Assistance Plan	Employer paid 100%	Provides counseling and other work and life resources and support.
Benefits Advocacy Services	Employer paid 100%	A personal advocate for your healthcare needs – benefit questions, claims assistance and much more.
Employee Share Purchase Plan	Employee/Employer contributions	Employees may elect to purchase on an annual basis up to $25,000 of Converge Common Shares under the Converge Employee Share Purchase Plan. A $25.00 per paycheck minimum. Converge will contribute an additional 20% of the employee's share purchase.
401(k)	Employee/Employer contributions	All full-time, new hires are auto-enrolled at 3%. Employees have the opportunity to choose pre-tax and Roth options. Converge offers an annual discretionary match: $.25 match for every dollar contributed, up to 6% of your annual earnings.

Key Definitions

Allowed Amount Maximum
Amount on which payment is based for covered medical services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may be subject to pay the difference. (See Balance Billing.)

Balance Billing
When an out-of-network provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary
A person who is designated as the recipient of proceeds from an insurance policy.

Co-insurance
Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if your plan has a 30% co-insurance rate, the Carrier will pay 70% of the allowed amount while you pay the balance.

Co-payment
A fixed amount that you pay at the time of service. Co-pays are most common for emergency room, urgent care and prescription drugs. In some cases, you may be responsible for paying a co-pay as well as percentage of the remaining charges.

Diagnostic Test
Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Deductible
The amount you must pay for eligible expenses before your plan begins to pay for benefits. A deductible may be per service/test, per visit, per supply or per coverage year. For example, many plans require an individual to pay $1,000 in cumulative deductibles before they begin paying out.

Eligible Expense
Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Explanation of Benefits (EOB)
Every time you use your health insurance, your health plan sends you a record called an “explanation of benefits” (EOB) or “member health statement” that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other healthcare professional is allowed to charge a plan member (called the “allowed amount”).

Generic Drugs
Medications that are comparable to brand name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand name counterparts.

Health Savings Account (HSA)
Similar to an FSA and funded through pre-tax payroll deductions by the employee (and sometimes employer contributions), HSAs are only available to people enrolled in a high-deductible health plan. Unlike an FSA, you don't "use-it-or-lose-it" – unused balances will roll over and accumulate over time and can be “cashed-out” (taxable implications may apply).

Key Definitions

Mail Order
Many carriers offer this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can usually obtain a 90-day supply at one time at a lower cost vs.30 day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your co-pay is almost always cheaper through mail order.

Medically Necessary
Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Negotiated Rate
Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Non-Preferred Brand Name Drugs
Typically, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand name drug or a generic.

Out-of-Pocket Limit
The most you will pay during a calendar year before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Payment Allowance
Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “negotiated rate” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Precertification or Prior Authorization
A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Preventive Care
Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

BENEFITS NOTICES

Benefits Notices: Table of Contents

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance:

- The Health Insurance Marketplace. 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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.

[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.

Health Insurance Exchange Notice

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

Rhonda Hanes
130 Technology Pkwy
Peachtree Corners, Georgia 30092 (770) 300-4798
rhonda.hanes@convergetp.com

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.

3. Employer Name Converge Technology Solutions	4. Employer Identification Number (EIN) 82-2782457	
5. Employer Address 130 Technology Pkwy	6. Employer Phone Number (770) 300-4798	
7. City Peachtree Corners	8. State Georgia	9. Zip Code 30092
10. Who can we contact about employee health coverage at this job? Rhonda Hanes		
11. Phone Number (770) 300-4798	12. Email Address rhonda.hanes@convergetp.com	

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

- As your employer, we offer a health plan to:
  - ✓ **Some employees.** Eligible employees are: full-time employees of the company, regularly scheduled to work at least 30 hours per week.
- With respect to dependents:
  - ✓ **We do offer coverage.** Eligible dependents are: depending on the benefit, your legal spouse, domestic partner (of the same or opposite sex who has signed the Domestic Partner Affidavit) and qualified dependent children.

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

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Rhonda Hanes at 130 Technology Pkwy, Peachtree Corners, Georgia 30092, (770) 300-4798, rhonda.hanes@convergetp.com.

Notice of Privacy Practices

Converge Technology Solutions
130 Technology Pkwy
Peachtree Corners, Georgia 30092
(770) 300-4798

Privacy Official
Rhonda Hanes
130 Technology Pkwy
Peachtree Corners, Georgia 30092 (770) 300-4798
rhonda.hanes@convergetp.com

Effective Date: 01/01/2022

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Notice of Privacy Practices

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a Copy of Health and Claims Records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask Us to Correct Health and Claims Records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request Confidential Communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask Us to Limit What We Use or Share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a List of Those with Whom We’ve Shared Information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a Copy of This Privacy Notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose Someone to Act For You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Notice of Privacy Practices

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Rhonda Hanes
  130 Technology Pkwy
  Peachtree Corners, Georgia 30092 (770) 300-4798
  rhonda.hanes@convergetp.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we **never** share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we Typically Use or Share Your Health Information?

We typically use or share your health information in the following ways.

Help Manage the Health Care Treatment You Receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Notice of Privacy Practices

Run Our Organization
- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for Your Health Services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer Your Plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with Public Health and Safety Issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research
We can use or share your information for health research.

Comply With The Law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Notice of Privacy Practices

Respond to Organ and Tissue Donation Requests and Work With a Medical Examiner or Funeral Director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to Lawsuits and Legal Actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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

Enrollment 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. Therefore, the following deductibles and coinsurance apply: $1,000, $2,000, $2,500, $3,000, $4,500, $7,500 or $9,000 deductible (in-network) and 0% or 20% coinsurance (in-network) and $3,000, $6,000, $7,500, $13,500, $22,500 or $27,000 deductible (out-of-network) and 50% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (770) 300-4798.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (770) 300-4798 for more information.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Converge Technology Solutions Employee Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (770) 300-4798.

Employer's Children's Health Insurance Program (CHIP) Notice

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 January 31, 2022. Contact your State for more information on eligibility.

Alabama - Medicaid	Arkansas - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
Alaska - Medicaid	**California - Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

Employer's Children's Health Insurance Program (CHIP) Notice

Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Iowa - Medicaid and CHIP (Hawki)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health- insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562
Florida - Medicaid	**Kansas - Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
Georgia - Medicaid	**Kentucky - Medicaid**
A 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	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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
Indiana - Medicaid	**Louisiana - Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Employer's Children's Health Insurance Program (CHIP) Notice

Maine - Medicaid	Nebraska - Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Massachusetts - Medicaid and CHIP	**Nevada - Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
Minnesota - Medicaid	**New Hampshire - Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
Missouri - Medicaid	**New Jersey - Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Montana - Medicaid	**New York - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

Employer's Children's Health Insurance Program (CHIP) Notice

North Carolina - Medicaid	South Dakota - Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://dss.sd.gov Phone: 1-888-828-0059
North Dakota - Medicaid	**Texas - Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
Oklahoma - Medicaid and CHIP	**Utah - Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
Oregon - Medicaid	**Vermont - Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
Pennsylvania - Medicaid	**Virginia - Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
Rhode Island - Medicaid and CHIP	**Washington - Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
South Carolina - Medicaid	**West Virginia - Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

Employer's Children's Health Insurance Program (CHIP) Notice

Wisconsin - Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

Wyoming - Medicaid

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 January 31, 2022, 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

Paperwork Reduction Act Statement

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

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

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

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).

Medicare Part D Creditable Coverage Notice

Important Notice from Converge Technology Solutions About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Converge Technology Solutions coverage will be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Converge Technology Solutions coverage, be aware that you and your dependents will be able to get this coverage back.

Medicare Part D Creditable Coverage Notice

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

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Rhonda Hanes at (770) 300-4798.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Converge Technology Solutions changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 04/14/2022
Name of Entity/Sender: Converge Technology Solutions Contact--Position/Office: Rhonda Hanes, VP Human Resources
Address: 130 Technology Pkwy Peachtree Corners, Georgia 30092
Phone Number: (770) 300-4798

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

General Notice of COBRA Rights

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

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

When is COBRA Continuation Coverage Available?

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

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

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

Rhonda Hanes
VP Human Resources
130 Technology Pkwy
Peachtree Corners, Georgia 30092
(770) 300-4798
rhonda.hanes@convergetp.com

How is COBRA Continuation Coverage Provided?

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

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

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

General Notice of COBRA Rights

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After my Group Health Plan Coverage Ends?

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

General Notice of COBRA Rights

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Converge Technology Solutions Employee Plan
Rhonda Hanes
130 Technology Pkwy
Peachtree Corners, Georgia 30092
(770) 300-4798
rhonda.hanes@convergetp.com

General FMLA Notice: Employee Rights Under The Family And Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12 month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

General FMLA Notice: Employee Rights Under The Family And Medical Leave Act

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

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USERRA Notice

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA- DOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

CONVERGE
TECHNOLOGY SOLUTIONS

Important Note

The information provided in this Guide is designed to be a partial description of the plans offered by Converge. Please consult your certificate booklets to determine the exact terms and conditions of coverage including all exclusions and limitations. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. Contact your Human Resources Team if you have any questions.