DBM GLOBAL | BUILDING HISTORY

2025 BENEFITS GUIDE

Hourly and Shop Employees

BUILDERS
As builders, we are committed to shaping the world around us

EXCELLENCE
We push onward & upward in our relentless pursuit of excellence

SERVANT LEADERSHIP
Supporting our workforce is our priority

TRANSPARENCY
Open communication is key to our success

TEAM
Together we succeed

BEST TEAM

DBM GLOBAL | AITKEN | BANKER STEEL | DBM VIRCON | Graywolf® | SCHUFF STEEL

Contents

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide for more details.

Statement of Material Modifications

This notice constitutes a Summary of Material Modifications (SMM) to the DBM Global Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Welcome

It's hard to believe a year has passed since our last benefits offering. This year has brought many challenges and successes for the DBM Global family of companies, and I am continually impressed by the resilience and dedication of our teams. Thanks to your hard work, we are the strong company we are today.

As many of you know, we have been focused on harmonizing benefits across our companies to provide the best possible package for all our employees and their families. Despite the ongoing rise in healthcare costs, we remain committed to offering a robust benefits package. The company has chosen to absorb the majority of these increased costs, ensuring we maintain a competitive offering that helps us attract and retain top talent in the industry.

Here are some highlights of this year's benefits offering:

- *Addition of TextCare for all employees enrolled in a medical plan*
- *All insurance carriers will remain the same including United Healthcare, Delta Dental of AZ, and EyeMed Vision*
- *Company contributions to Health Savings Accounts for employees enrolled in the High Deductible Health Plan ($400 for individuals / $800 for families)*
- *Employer contributions for dental coverage (new for Banker Steel and GrayWolf)*
- *Employer-paid life insurance and short-term disability for office and shop employees*

As we look ahead to 2025, I want to express my gratitude for your commitment to making DBM Global and our family of companies the best in the industry. I believe that our Core Values; Builders, Excellence, Servant Leadership, Transparency and Team capture the collective spirit of our company which continues to set us apart. Your efforts truly make a difference.

Sincerely,

Rustin Roach

Rustin Roach
CEO & Chairman

Benefits Overview

DBMG is committed to providing you a comprehensive benefit program. Our benefits package includes medical, dental, and vision to support employees' health and wellness needs. Additionally, life and disability coverage is available to provide financial protection and peace of mind for employees and their families. A significant portion of your monthly premium is paid by the Company for some benefits, while other benefits require an employee contribution as noted below:

Benefit	Who Pays	Tax Treatment
Medical	DBMG and You	Pre-Tax
Dental	DBMG and You	Pre-Tax
Voluntary Vision	You	Pre-Tax
Basic Life and AD&D	DBMG	N/A
Voluntary Life and AD&D	You	Post-Tax
Company-Paid Short Term Disability (STD)	DBMG	N/A
Voluntary Long Term Disability (LTD)	You	N/A
Health Savings Account (HSA)	DBMG and You	Pre-tax
Flexible Spending Accounts (FSA) Healthcare FSA, Limited Purpose FSA, Dependent Care FSA	You	Pre-Tax
Business Travel Accident Insurance	DBMG	N/A
Identity Theft & Credit Protection	You	Post-Tax
401(k) Retirement Plan	DBMG and You	N/A

Enrollment Instructions

Annual Open Enrollment

For the 2025 plan year, open enrollment is ***passive.*** This means your current elections will carry over to the next year unless you make any changes. However, you must **re-enroll** in the Health Savings Account and Flexible Spending Accounts as they do not carry over.

If you need to make changes to your benefits during this year's enrollment, visit Paycom via your computer or smart phone. Enrollment instructions are below.

New Hire Open Enrollment

Newly hired employees will have up to 60 days from their date of hire to complete the new hire open enrollment. Please remember the elections you make will stay in place for the entire year unless you experience a qualifying life event.

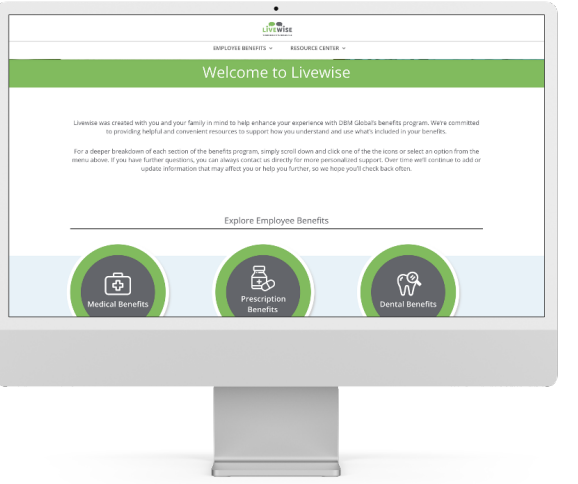
Enrollment Instructions
1. **Log into the Paycom app.** From the Notification Center or from the Benefits section, click the current year's Benefits Enrollment.
2. **Review and start your enrollment.** Review the initial instructions and click "Start Enrollment." Then, enter your personal information and any dependents or beneficiaries.
3. **Enroll or decline.** After reading each benefit plan, choose your coverage, and then elect either to enroll or decline.
4. **Complete.** To complete enrollment, click "Finalize", then "Sign and Submit.

LiveWise

DBMG's communications page is another way we are creating an enhanced user experience for your and your family!

We encourage you to check out our benefits website at http://LiveWise.Info. This site was designed with you in mind and provides you and your family with great information on all benefits DBMG offers!

LiveWise Features
An improved member experience makes benefits information convenient and simple.
Access important websites all from one central, easy-to-read page.
Learn more about your benefits and find helpful resources.



Benefit Guides

Easily access your Benefit Guide – whenever, wherever! All DBMG Benefit Guides are housed on LiveWise so you can reference this information throughout the year.

Helpful Resources

Here you will find a glossary of important benefits and insurance terms, as well as communication articles to further educate yourself.

Frequently Asked Questions

We've made it easy for you and your family to access the answers to frequently asked questions on the LiveWise portal. These include questions, such as:

- **When is Open Enrollment?**
- **What is a Qualifying Life Event?**
- **Who is our dental plan carrier?**

Eligibility and Enrollment

Eligibility

Employees: You are eligible for DBMG benefits if you are a regular full-time employee working 30 or more hours per week.

Dependents: Your dependents are eligible for benefits based on the following guidelines:

- Legal Spouse
- You or your legal spouse's eligible children up to age 26 regardless of marital or student status
    - Includes natural children, stepchildren, foster children, adopted children, dependent children placed with you for adoption, and other children, for whom the courts have granted you legal custody
- Disabled Dependent Children – an unmarried child of any age who is incapable of supporting themselves due to a mental or physical disability and who are dependent on you

Benefits Effective Date

Your benefits will begin on the 1st day of the month after you have completed 30 full days of employment. *For example, if you are hired on March 15th, your benefits would begin on May 1st.*

Benefits Enrollment Date

If you are a newly hired employee, your enrollment window begins after your 1st day of employment and remains open for **60 days**. If you do not elect benefits within this 60-day period, you must wait until the next Annual Open Enrollment period to enroll in benefits unless you experience a qualifying life event.

Qualifying Life Events (QLE)

You have **30 days** from the date of any Qualifying Life Event (QLE) to make changes to your benefits.

QLEs include, but are not limited to:

- Birth / Adoption
- Marriage, Divorce or Legal Separation
- Child Status Change
- Spouse Gains / Loses Coverage
- Employee Gains / Loses Coverage
- Death of a Dependent

Documents for QLEs

Here are some of the approved documents you can provide to HR, should you experience a QLE.

- Marriage Certificates
- Birth Certificate or Hospital Birth Record
- Death Certificate
- Carrier Confirmation
- Court Documents

Employees can initiate a QLE in Paycom within 30 days. Documentation is required to process the change made to your coverage depending on the benefit event that has occurred.
For more information, visit http://LiveWise.Info.

Medical and Pharmacy

DBMG offers three medical plan options through UnitedHealthcare (UHC) – two PPO plans and a High Deductible Health Plan (HDHP) with HSA. All plan options utilize the same *Choice Plus Network* of providers and cover the same services. The plans vary by deductible, copays, and weekly premiums.

Please take a moment to review the plans to ensure you choose the one that best meets your needs. A side-by-side plan comparison chart is on the next page highlighting the most utilized benefits. For a full summary of benefits visit http://LiveWise.Info.

Employee Contributions (Per Week)			
	$500 Deductible	**$2,000 Deductible**	**HDHP with HSA**
Employee	$97.00	$33.00	$21.00
Employee + Spouse	$185.00	$87.00	$57.00
Employee + Child(ren)	$183.00	$83.00	$55.00
Family	$241.00	$133.00	$88.00

The medical rates for active, full-time employees are effective from January 1, 2025 – December 31, 2025. Benefits are not available to part-time employees, except employees who average 30 or more hours per work week who are considered full-time for the purposes of the Affordable Care Act (ACA). If paid bi-weekly, your rates will be adjusted accordingly.

Medical and Pharmacy Benefits

UHC Medical Benefits			
	$500 Deductible	**$2,000 Deductible**	**HDHP with HSA**
	In-Network	**In-Network**	**In-Network**
Annual Deductible *Individual / Family*	$500 / $1,000	$2,000 / $4,000	$3,300 / $6,600
Annual Out-of-Pocket Max *Individual / Family*	$5,500 / $11,000	$8,150 / $16,300	$5,000 / $10,000
Preventive Services	No charge, covered 100%	No charge, covered 100%	No charge, covered 100%
Primary Care Office Visit *Designated Network / Network*	$25 / $50	No charge, covered 100%	30% after deductible
Specialist Office Visit *Designated Network / Network*	$50 / $80	$95 Copay	30% after deductible
Diagnostic Lab and X-ray	20% after deductible	20% after deductible	30% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	30% after deductible
Urgent Care	$50 Copay	$50 copay	30% after deductible
Emergency Room	$400 Copay	$400 copay + 20% after deductible	30% after deductible

UHC Pharmacy Benefits			
	$500 Deductible	**$2,000 Deductible**	**HDHP with HSA**
	In-Network	**In-Network**	**In-Network**
Preventive Rx	Not applicable	Not applicable	Preventive Rx covered at 100%
Generic	$10 copay	$10 copay	$10 copay after deductible
Preferred Brand	$35 copay	$35 copay	$35 copay after deductible
Non-preferred Brand	$70 copay	$70 copay	$70 copay after deductible

TextCare

Managed by One to One Health

Welcome to TextCare!

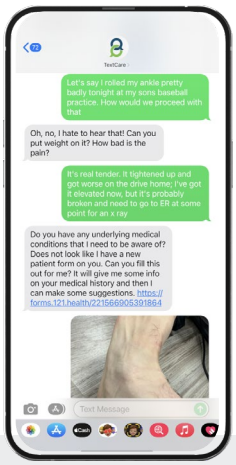
- With TextCare, you can discuss primary and urgent care needs, chronic condition management and routine medication needs.
- Get support for you and your family finding high quality value specialists.
- TextCare is easily accessible via text message and video chat. Simply send them a text message to initiate care. It's that easy!
- TextCare is available to you and your entire household – this includes your spouse and/or your dependents.
- TextCare takes privacy seriously. They are highly compliant with all HIPAA and healthcare regulations to maintain your privacy, ensuring your health information is kept confidential.

What can you use TextCare for?

Your care team can help with any health or medical question and should be your first point of contact for any issue. Even if your issue cannot be resolved virtually, the care team provides expert care navigation and will refer you to specialty providers. If you're in need of medication, your TextCare provider can prescribe medication, and the prescription will be sent to a local pharmacy.

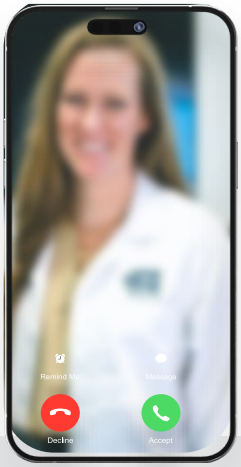
TextCare is available 24/7 and can help you avoid unnecessary visits to the urgent care or emergency room, in addition to saving you and your family money!

To get started, send a text message to initiate care! Your care team will respond within 5 minutes – no appointments necessary and you do not need to download an app.



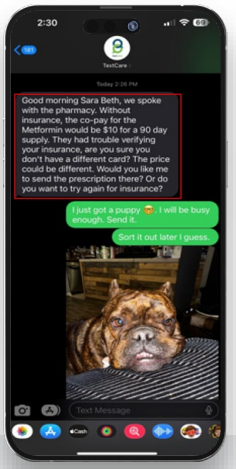
TEXT

94% of patients prefer text as their favorite communication channel with their provider. **26%** of all text encounters include a picture or video from the patient.



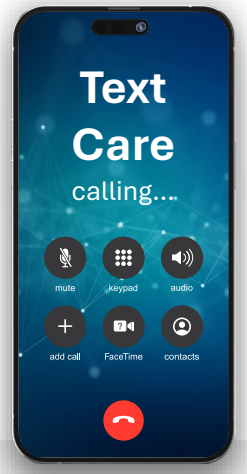
VIDEO CHAT

Browser-based WebRTC video call functionality enables one-click video calls with clinicians, straight from the TextCare thread.



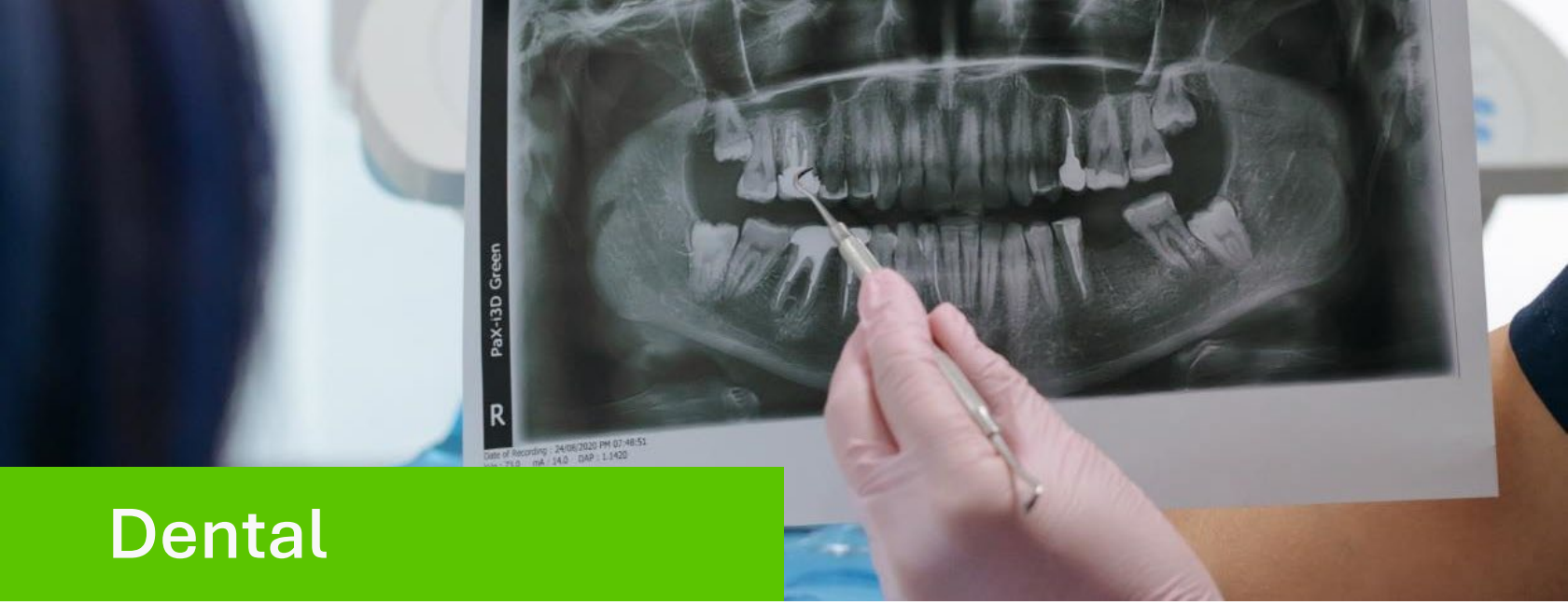
ENCRYPTED CHAT

Fully-encrypted chat functionality for sensitive and protected information.



CALL

Providers can initiate a call, or members can simply call their dedicated number to access care.



Dental

Great news, there are no changes to the dental plan, or rates, for the 2025 plan year! Although Delta Dental allows you to visit any provider you like, staying in the **PPO and Premier Network** will provide you with the highest level of benefits. Non-network providers may balance bill you for an amount above what is considered "Reasonable & Customary."

Visit www.deltadentalaz.com to find providers in our network or call (800) 352-6132.

Delta Dental of Arizona	
	In-Network
Annual Deductible *Individual / Family*	$50 / $150
Annual Maximum *Includes Basic and Major Services*	$1,500 per person
Diagnostic and Preventive *Oral Exam, Cleanings, X-rays, Fluoride*	No charge, covered at 100%
Basic Services *Fillings, Endodontics, Periodontics, Sealants*	20%
Major Services *Crown Repair, Prosthodontics, Relines and Repairs for Bridges and Dentures*	50%
Orthodontia *Adults and Children*	50%
Orthodontia Lifetime Maximum	$2,000 per person

Employee Contributions *(Per Week)*	
Employee	$3.00
Employee + Spouse	$5.85
Employee + Child(ren)	$5.78
Family	$9.42

Reminder!

Our plan allows for **3 FREE cleanings** per year!

Voluntary Vision

Vision benefits will continue to be provided through EyeMed Vision Care on the Insight Network. EyeMed has a broad network of independent providers as well as LensCrafters®, Target Optical®, and most Pearle Vision® locations. For a complete list of providers near you, visit eyemed.com and choose the Insight Network or call (866) 4-EYEMED.

EyeMed Vision	
	In-Network
Exam with Dilation as Necessary	$10 copay
Exam Options *Standard Contact Lens Fit and Follow up* *Premium Contact Lens Fit and Follow Up*	 Up to $55 10% off retail price
Frames	$150 allowance + 20% off balance
Single Lenses Bifocal Lenses Trifocal Lenses Standard Progressive Lenses	$10 copay $10 copay $10 copay $75 copay
Premium Progressive Lenses *Tier 1* *Tier 2* *Tier 3* *Tier 4*	 $95 copay $105 copay $120 copay $75 copay; 80% of charge, less $120 allowance
Lens Options *UV Coating / Tint (Solid and Gradient)* *Standard Scratch-Resistance* *Standard Polycarbonate* *Standard Anti-Reflective*	 $15 copay $15 copay $40 copay $45 copay
Contact Lenses *(In lieu of glasses)*	$150 allowance + 15% off balance
Frequency *Exam | Lenses | Frames*	 12 months | 12 months | 12 months
Employee Contributions *(Per Week)*	
Employee	$1.34
Employee + Spouse	$2.31
Employee + Child(ren)	$2.44
Family	$3.85

Life Insurance

The life, AD&D, and disability insurance plans through Mutual of Omaha can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

In addition to the company-paid benefits, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

Basic Life

DBMG provides a flat Basic Life insurance benefit of 1x your annual salary up to $100,000. If your death is caused by an accident, the plan includes an AD&D feature that pays an additional $100,000, doubling your benefit amount.

Voluntary Life and AD&D

In addition to the Basic Life insurance provided by DBMG, you may choose to buy additional Voluntary Life and AD&D coverage for you and your family. Employees must elect voluntary life coverage for dependents to participate.

Employee: Increments of $10,000 up to $500,000, maximum of 10x annual salary
- *Guarantee Issue: $200,000 for new enrollees only**

Spouse: Increments of $5,000 up to $250,000
- *Guarantee Issue: 100% of employee benefit, up to $50,000**

Child(ren): Options of $5,000 or $10,000

**** Voluntary Life and AD&D is not an Open Enrollment benefit.*** If you did not enroll when you were newly hired, you will be required to complete medical Evidence of Insurability.

Disability Insurance

DBMG provides disability coverage at no cost to eligible employees through Mutual of Omaha. Disability coverage helps provide financial security for you and your family in the event you become sick or injured and are unable to work. Employees are automatically enrolled in benefit when eligible.

Company-Paid Short Term Disability (STD)

STD coverage pays you a benefit if you temporarily can't work because of an injury, illness or maternity leave. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

- **Weekly Benefit:** 60% of your total weekly earnings up to $1,200
- **Benefits begin** on the 8th day of disability
- **Maximum Payment Period:** 13 weeks

Voluntary Long Term Disability (LTD)

LTD coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long period of time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

- **Monthly Benefit:** 60% of your monthly earnings up to $5,000
- **Benefits begin** after 90 days
- **Benefit Duration (if disabled prior to age 62):** Benefits continue until age 65 if you remain disabled.
- **Benefit Duration (if disabled at age 62 or older):** Benefits continue until your Social Security Normal Retirement Age if you remain disabled.

Mutual of Omaha Additional Resources

With Mutual of Omaha, you have access to various tools and resources, including an Employee Assistance Program (EAP), Will Preparation Assistance and Worldwide Travel Assistance. Below is a highlight of these resources – more information can be found at http://LiveWise.Info.

Get help 24/7/365 by calling (800) 316-2796 or visiting www.mutualofomaha.com/eap

EAP: Employees can receive up to **six (6) FREE face-to-face counseling sessions** in your local area. It includes services like legal/financial advice and help finding childcare, all to help you manage your busy lifestyle.

Will Preparation: Mutual of Omaha's free online interactive tool helps you and your family members create a will and other legal documents. For more information, visit www.mutualofomaha.com.

Worldwide Travel Assistance: When you travel 100 miles or more from home on company business or vacation, emergency medical and travel services are available. Translation / interpretation services, and emergency medical evacuation assistance are some of the services available to you.

Health Savings Account

Health Savings Account

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. It is a tax-advantaged, savings account that is offered if you enroll in the High Deductible Health Plan (HDHP). You and DBMG can contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money you don't spend grows year after year and can be used in the future, even after you retire.

HealthEquity is the company that administers this account. An account will be automatically created when you enroll in the HDHP. Visit www.healthequity.com for more information.

How the HealthEquity HSA works

To help you get started, DBMG contributes to your HSA.

DBMG Employer Contributions:

- Employee Only: $400
- Employee + Dependents or Family: $800

These contributions are split into two payments in late January and July.

2025 IRS Maximum Contribution Limits (Including Employer Contributions)

- Employee Only: $4,300
- Employee + Family: $8,550

You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four Reasons to Have an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Are you eligible?

You are eligible to contribute to an HSA if:

- You are enrolled in the **HDHP** plan
- You are not covered by your spouse's health plan
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare, Medicaid, TRICARE for life or VBA.

Flexible Spending Accounts

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (FSA), through HealthEquity, allows you to contribute pre-tax dollars to pay for medical, dental or vision expenses not reimbursed by your health plan. The Health Care FSA can be used by you, your spouse and dependent children.

PLEASE NOTE: *To participate in the Health Care FSA, you must enroll in this plan each year, even during a passive open enrollment. Elections made in 2024 will not continue in 2025.*

How To Use Your Health Care FSA

You decide how much to contribute to your Health Care FSA each year, with a minimum contribution of $200 and a maximum of $3,300**.** You will receive a debit card from HealthEquity to use for eligible expenses.

Eligible Expenses Include:

- Office Visit Copays
- Deductible and Coinsurance
- Prescription Medication
- Chiropractic Care, Acupuncture, and Physical Therapy Expenses

For a complete list of eligible expenses, refer to IRS Publication 502 or visit www.LivwWise.info.

Don't Lose Your Funds

Carefully consider your contributions to the Health Care FSA. The money you set aside must be used during the plan year – it will not roll over from year to year. **Any funds not used will be forfeited.**

Limited Purpose Flexible Spending Account

The Limited Purpose Flexible Spending Account (LPFSA), is specifically designed for employees enrolled in the HDHP and Health Savings Account (HSA). An LPFSA can be used alongside an HSA, allowing you to maximize your tax-free savings. You can use HSA funds for medical expenses while using **LPFSA funds for dental and vision care only.**

Flexible Spending Accounts

Dependent Care Flexible Spending Account (DCFSA)

A Dependent Care Flexible Spending Account (DCFSA), through HealthEquity, allows you to contribute pre-tax dollars to pay for eligible dependent care expenses. Eligible dependents includes, children under age 13, a disabled spouse, or an older parent in eldercare. You must re-enroll in this plan each year.

When enrolling, you decide how much money you want to put into your account for the year on a pre-tax basis, up to the IRS limits. When you have an expense that qualifies for reimbursement, you can submit a claim with any necessary documentation, and you will receive a tax-free reimbursement.

The minimum amount you can contribute to your DCFSA for 2025 is $200 a year, and the maximum amount you can contribute is $5,000 (If you are married and file a separate tax return, your annual maximum contribution is $2,500 a year).

Don't Lose Your Funds

Carefully consider your contributions to the DCFSA. Any unused funds are forfeited per IRS regulations. Expenses need to be incurred before the last day of the year or your last day of employment.

Claim Reimbursements

You can only receive reimbursement up to the amount that has been payroll deducted to date. Claim reimbursement is based on the date you receive the dependent day care service, not the date you pay the invoice or the date you are billed. The DCFSA plan year runs from January 1, 2025, through December 31, 2025, and you have until March 15, 2026 to submit claims.

Eligible Expenses

Here are some of the most common Dependent Care eligible expenses. A full list of eligible expenses can be found at www.healthequity.com or on IRS Publication 502.

Common Eligible Expenses
Payments to nursery schools, day care centers or individuals who satisfy all state and local laws and regulations
Payments for before-school care and after-school care beginning with kindergarten and higher grades
Payments to relatives for care of a qualifying dependent(s); however, the relative cannot be your tax dependent or your child if under age 19 as of the end of the calendar year; and
Payments (in lieu of regular day care) to day camp (for example, soccer, computers, etc.), but not overnight camps

401(k) Plan

Eligible employees are **automatically** enrolled to contribute 6% of your eligible pay in the Principal 401(k) plan. Participation begins on the first day of the month following 30 days of employment. You may change your contribution rate at any time.

Growing Your Account Balance

Traditional 401(k) Contribution
You can contribute from 1% - 100% of your eligible pay (up to $23,500 for 2025) on a **pre-tax** basis. If you turn age 50 during the year, you can contribute an additional $7,500 to the plan.

Roth 401(k) Contribution
Make Roth contributions on an **after-tax** basis through payroll deductions. This means you pay taxes in the year contributions are made, and withdrawals (earnings and contributions) are income tax free, provided you are at least age 59 ½ and the account has been open for at least five years.

Employer Match
DBMG matches 100% of the first 3% you contribute and 50% of the next 2% you contribute. You will become fully vested in your employer match after 2 years of employment.

Investments
You have a variety of investments to choose from. You can either "build your own portfolio," select a "pre-built portfolio," which is an investment option that is based on your expected retirement age (called "Target Date Funds"), or you can select the plan's professionally managed investment solution (called "Target My Retirement").

To Manage Your Account

Go to www.principal.com or contact the Principal Customer Service Center at (800) 547-7754. As a reminder, when calling Principal, our employer plan is DBM Global, Inc, 3-27432.

Additional Benefits

DBMG's benefits program includes other valuable tools and resources, in addition to our core benefits package. We are proud to partner with these carrier and vendor partners to enhance our offerings for you and your family. Take a moment to review the highlights of our additional benefit offerings here and visit http://LiveWise.Info for further details.

Business Travel Accident Insurance (Company-Paid Benefit)
You have access to 24/7 Business Travel Accident insurance through Chubb Accident & Health.

Working Advantage
This is a discount program that can help you save up to 60% on tickets, travel and shopping.

Verizon Wireless
You may be eligible for an 18% discount with Verizon Wireless.

InfoArmor Identity Theft and Credit Protection
InfoArmor is an identity theft protection and credit monitoring service.

Nationwide Pet Insurance
DBMG is pleased to continue offering Nationwide Pet Insurance. This is a great way to demonstrate how much you value every member of your family – even the four-legged ones.

HUSK Marketplace
DBMG has partnered with HUSK Marketplace, formerly known as GlobalFit, to provide the wellness tools, resources, and access that enables people to exist with more intention and fulfillment in ways that work for them and their communities.

2025 Holiday Schedule

2025 Paid Holidays

DBMG provides 8 paid holidays per year for all eligible employees.

Observed Holidays	
New Year's Day	January 1
Memorial Day	May 26
Independence Day	July 4
Labor Day	September 1
Thanksgiving	November 27
Day after Thanksgiving	November 28
Christmas Eve	December 24
Christmas Day	December 25

Important Contacts

Navigating your benefits can be confusing, but it doesn't have to be! Your benefits team is here for you. If you have questions about who to contact, call the DBMG Benefits Team first and we will point you in the right direction to get the quality customer assistance you need. Otherwise, you can contact any of the providers listed below.

PROVIDER / BENEFIT	POLICY NUMBER	PHONE NUMBER	WEBSITE
UnitedHealthcare *Medical and Pharmacy*	0923344	(866) 633-2446	myuhc.com
Delta Dental of Arizona *Dental*	4409	(800) 352-6132	deltadentalaz.com
EyeMed *Vision*	1011446	(866) 723-0513	eyemed.com
Mutual of Omaha *Life and AD&D* *Disability* *Employee Assistance Program*	G000BM92	(800) 775-8805 EAP: (800) 316-2796	mutualofomaha.com mutualofomaaha.com/eoi mutualofomaha.com/eap
HealthEquity *Health Savings Account* *Flexible Spending Account*		(866) 346-5800	myhealthequity.com
InfoArmor *Identity Theft Protection*		(800) 789-2720	infoarmor.com
Nationwide *Pet Insurance*		(877) 738-7874	PetsNationwide.com
Principal *401(k)*	*3-27432*	(800) 547-7754	principal.com
HUSK Marketplace (Formerly GlobalFit)		(800) 294-1500	Huskwellness.com
Working Advantage *Ticket, Travel Discounts*		(800) 565-3712	workingadvantage.com
Verizon Wireless Discount Program		(800) 775-8098	verizonwireless.com

Legal Notices

Availability of Privacy Practices Notice
We maintain the HIPAA Notice of Privacy Practices for DBMG Global. describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the DBMG Benefits Manager (benefits@dbmglobal.com).

Notice of Choice of Providers
UnitedHealthcare generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UnitedHealthcare at the member services number on the back of your ID card.

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

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

HIPAA Notice of Special Enrollment Rights
If you decline enrollment in DBM Global' s health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in DBMG Global 's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in DBM Global 's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility—

Legal Notices

ALABAMA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
ALASKA – Medicaid	**KANSAS – 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: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
ARKANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)	Kentucky Integrated Health Insurance Premium Payment Program Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
CALIFORNIA – Medicaid	**LOUISIANA – Medicaid**
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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711; CHP+: https://hcpf.colorado.gov/child-health-plan-plus; CHP+ Customer Service: 1-800-359-1991 | State Relay 711; Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442	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
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2	Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
INDIANA – Medicaid	**MISSOURI – Medicaid**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

Legal Notices

MONTANA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov	Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
NEBRASKA – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178	Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov | Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
NEW YORK – Medicaid	**VERMONT – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100	Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825	Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742	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)
OREGON – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

Legal Notices

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- $500 Deductible, 20% Coinsurance
- $2,000 Deductible, 20% Coinsurance
- $3,300 HDHP, 30% Coinsurance

If you would like more information on WHCRA benefits, contact DBMG Benefits Manager (benefits@dbmglobal.com).

Newborns' and Mothers' Health Protection Act

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

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.
View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

Medicare Part D Notice
Important Notice from DBM Global About Your Prescription Drug Coverage and Medicare
Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with DBM Global 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. DBM Global has determined that the prescription drug coverage offered by UnitedHealthcare 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.

Legal Notices

Medicare Part D Notice
Important Notice from DBM Global About Your Prescription Drug Coverage and Medicare Creditable Coverage Notice *(continued)*

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 DBM Global coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under UnitedHealthcare is **creditable** (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your DBM Global prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 CLIENT 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. 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 CLIENT changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	January 1, 2025
Name of Entity:	DBM Global
Contact:	Tori Sepiol
Email Address:	Tori.Sepiol@dbmglobal.com
Phone Number:	(480) 718-0984

DBM GLOBAL

BUILDING HISTORY