Employee Benefits

2023

TEAM®

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Working together is what makes TEAM a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This guide offers details on your 2023 benefits. Contact the Human Resources department with any questions.

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In this Guide, we use the term company to refer to TEAM, Inc. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility and Enrollment

TEAM's benefits are designed to support your unique needs.

Eligibility

If you are a regular, full-time employee of TEAM who is U.S. based, U.S. paid, and consistently works at least 30 hours per week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

If you are a new hire, you must enroll in benefits within 60 days of your date of hire. Your coverage will begin the first of the month following your date of hire. **If you do not enroll within 60 days of your date of hire, you will not have any coverage.** You won't be able to enroll until the next Open Enrollment unless you have a qualifying life event. If you elect benefits or make changes during the Open Enrollment Period, your new coverage will begin on January 1.

Note

Open Enrollment is your annual chance to choose your benefits, unless you have a qualifying life event, such as marriage or the birth/adoption of a child.

Dependents

Dependents eligible for coverage in the TEAM benefits plans include:

- Your legal spouse or domestic partner.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, children who are the subject of a Qualified Medical Child Support Order (QMCSO) issued to you, and children for whom legal guardianship has been awarded to you or your spouse).
- Your disabled children of any age, if unmarried and mentally or physically handicapped, incapable of self care, incapable of self-sustaining employment (if disabled before age 26), and **enrolled** in the plan prior to age 26. Verification of dependent eligibility is required upon enrollment.

Now's the Time to Enroll!

What are Qualifying Life Events?

You can enroll in benefits as a new hire or during Open Enrollment, but changes in your life called Qualifying Life Events (QLEs), determined by the IRS, can allow you to enroll in health insurance or make changes mid-year outside of Open Enrollment.

When a Qualifying Life Event occurs, you have **31 days** to request changes to your coverage. Your change in coverage must be consistent with your change in status.

Common qualifying events include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Changes in address or location that may affect coverage
- Entitlement to Medicare or Medicaid

Some lesser-known qualifying events are:

- Child dependent turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

All life events must be initiated and completed in Workday by selecting the applicable event, making the requested changes, uploading the supporting documentation, and submitting the event within 31 days from the date of the event.

Preparing for Enrollment

TEAM covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the higher your portion.

Enrollment Action Items

Update your personal information.

If you've experienced any life changes since the last Open Enrollment period — such as the birth of a child or a move — you may need to change your elections or update your pertinent details.

Double-check covered medications.

If you make any changes to your plan, consider how it affects your prescriptions.

Review available plans' deductibles.

Foresee a lot of medical needs this year? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.

Going in-network often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.

You may select any combination of medical, dental, and/or vision plan coverage. For example, you could select medical coverage for you and your entire family but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of TEAM, must elect coverage for yourself in order to elect any dependent coverage.

Medical Benefits

Medical benefits are provided through Blue Cross Blue Shield of Texas (BCBSTX) and Kaiser. Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2023 plan year unless you have a qualifying life event.

How to Find a Provider

Visit bcbstx.com or call Customer Care at 800-521-2227 for a list of Blue Cross Blue Shield of Texas (BCBSTX) network providers.

You have the option to choose from 3 medical plans administered by Blue Cross Blue Shield of Texas (BCBSTX)

If you live in California you will also have the option of an HMO plan through Kaiser.

Consumer Driven Health Plan	PPO Plan 1	PPO Plan 2

How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How does a CDHP (Consumer Driven Health Plan) work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

Medical Plan Summary

This chart summarizes the 2023 medical coverage provided by BCBSTX. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	CDHP		PPO PLAN 1		PPO PLAN 2	
	IN-NETWORK	OUT-OF-NETWORK[3]	IN-NETWORK	OUT-OF-NETWORK[3]	IN-NETWORK	OUT-OF-NETWORK[3]
2023 HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FROM TEAM						
EMPLOYEE ONLY OR EMPLOYEE AND SPOUSE	$750		No contribution		No contribution	
EMPLOYEE AND CHILDREN OR FAMILY	$1,500					
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$3,000	$6,250	$2,000	$5,000	$1,250	$3,125
FAMILY	$6,000[2]	$12,500[2]	$6,000	$15,000	$3,750	$9,375
COINSURANCE (YOU PAY)	20%*	50%*	30%*	60%*	20%*	40%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)[7]						
INDIVIDUAL	$6,000	$12,500	$6,000	$12,000	$3,750	$9,375
FAMILY	$12,000	$25,000	$12,000	$24,000	$11,250	$28,125
COPAYS/COINSURANCE						
PREVENTIVE CARE	No charge	50%*	No charge	60%*	No charge	40%*
BLUE DISTINCTION PROVIDER	20%*	50%*	$25	60%*	$25	40%*
PRIMARY CARE	20%*	50%*	$40	60%*	$35	40%*
VIRTUAL VISITS WITH MDLIVE[1]	20%*	N/A	$30	N/A	$25	N/A
SPECIALTY CARE	20%*	50%*	$50	60%*	$45	40%*
EMERGENCY ROOM[6]	20%*		30%*		$250 copay (waived if admitted)	
URGENT CARE	20%*	50%*	$35	60%*	$35	40%*
INPATIENT HOSPITAL[4]	20%*	50%*[5]	$250 + 30%*	$500 + 60%*[5]	20%*	$500 + 40%*[5]
OUTPATIENT SURGERY	20%*	50%*	30%*	60%*	20%*	40%*

*After deductible

[1] Virtual visits with regular providers are at normal copay levels.

[2] The CDHP has an aggregate deductible, meaning the entire family deductible must be paid out-of-pocket before the plan pays for services for any family member. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan.

[3] If you use an out-of-network provider, you are responsible for any charges above the reasonable and customary limit.

[4] Inpatient Hospital: Pre-certification required.

[5] Inpatient Hospital Out-of-Network: You pay a $350 penalty if you fail to pre-certify your hospital stay.

[6] Care Coordination must be notified within two days. Coverage for true emergencies only.

[7] Expenses that count toward meeting your out-of-pocket maximum include medical plan coinsurance and copays, prescription drug coinsurance and copays, and amounts you pay toward the deductible. Amounts above the reasonable and customary charge for out-of-network care do not count toward your out-of-pocket maximum.

Fertility Coverage

Deciding to start a family is an exciting yet complicated decision to make. TEAM is excited to offer fertility benefits that can help ease some of the stress when making this important life decision. If you are enrolled in one of the Blue Cross Blue Shield of Texas Medical Plans, you will have access to this new benefit. There is a $30,000 lifetime max and some limitations. Please refer to your plan documents for more details.

BCBSTX Programs

Livongo

Livongo, brought to you by BCBSTX, helps you stay on top of your health. Programs include Diabetes Management and Blood Pressure Management through personalized support for all your health needs.

Modern Diabetes Program Benefits

- Get advanced meters, unlimited strips, lancets and on-demand coaching.

Better Blood Pressure Simplified

The Livongo for Hypertension program offers a simple, advanced blood pressure monitor combined with the power of personalized coaching 100% paid for by your employer.

To Learn More About Livongo and Get Started

- Text “GO BCBSTX” to 85240 to learn more & join.
- You can also join by visiting join.livongo.com/BCBSTX/register or by calling 800-945-4355 and use registration code: BCBSTX.

Hinge Health

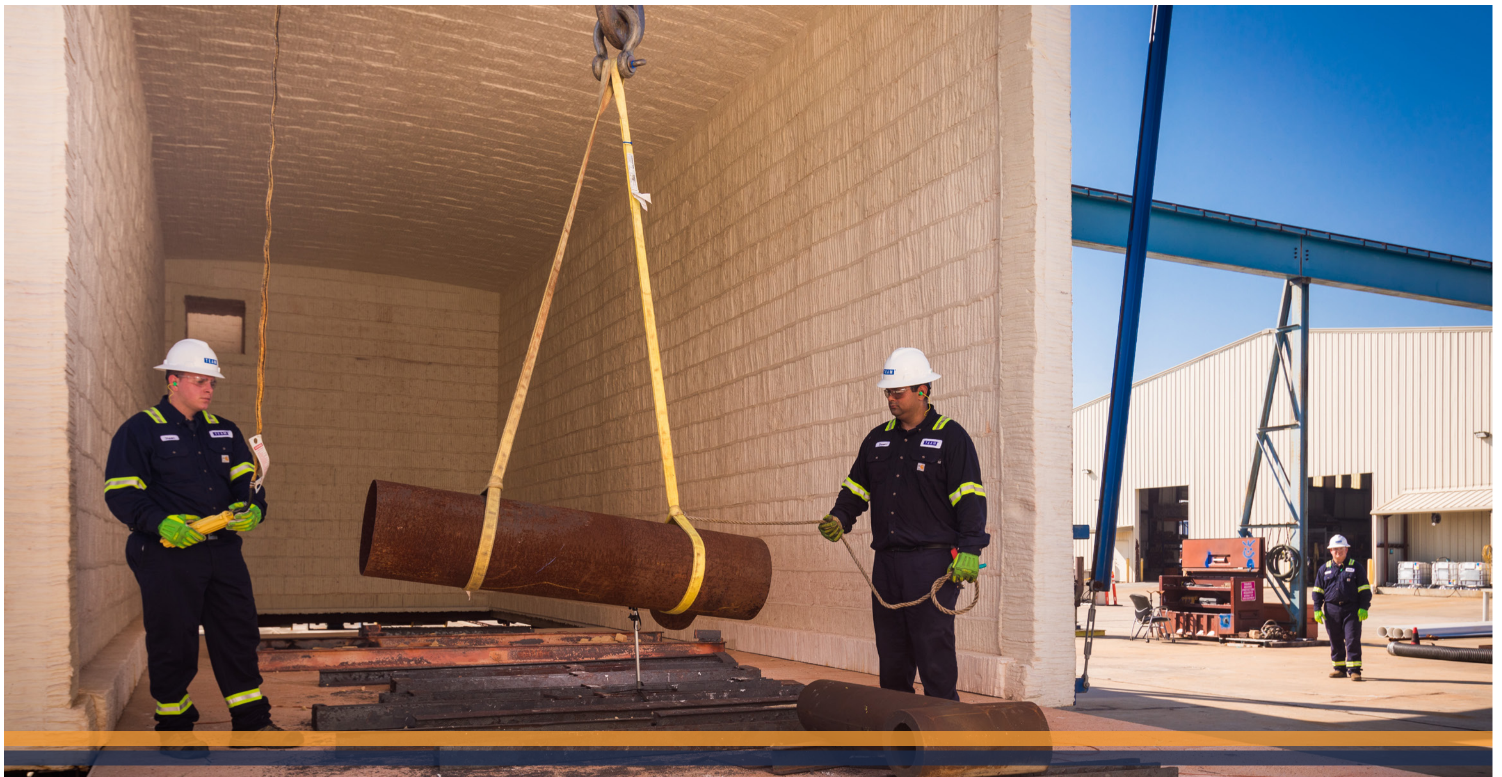
As a member of BCBSTX, you get access to a new innovative digital program for chronic back, knee, hip, shoulder and neck pain at no cost to you. This program, provided by Hinge Health, includes:

- A tablet computer and wearable sensors
- Unlimited one-on-one health coaching
- Personalized exercise therapy

Over 30,000 participants have enrolled in their programs so far and cut their pain by over 60%!

Questions?

- Call the number on the back of your member ID card.
- Learn more at hingehealth.com



Airrosti

Airrosti

Airrosti provides highly effective, personalized care for acute and chronic musculoskeletal pain and conditions. Each Airrosti treatment plan, in-person or virtual, includes:

- Thorough assessments and orthopedic testing to provide an accurate diagnosis and injury education.
- Conservative manual treatment to restore function, increase mobility and reduce pain.
- Personalized, active rehab and at-home exercises designed to speed recovery and prevent future injuries.

The goal is to give patients a quick and safe return to activity.

Airrosti proudly offers two convenient, highly effective care options to help you live life pain free. Experience the Airrosti difference with:

- **Expert diagnosis.** Your provider will perform a thorough orthopedic and functional evaluation to accurately diagnose your injury and develop your targeted care plan.
- **Effective care.** Airrosti's safe and efficient care results in increased strength, function and range of motion, as well as dramatic decrease in pain.
- **Personalized Plan.** You will receive a customized exercise and recovery plan designed to target the source of your plan and speed recovery.

Pain Airrosti Treats

Below are some common injuries our doctors treat on a daily basis:

- Hip
- Back
- Neck
- Shoulder
- Foot
- Plus more!

Note

- 99.6% Patient Satisfaction
- 15,000+ Physician-recommended surgeries avoided
- 88.3% Injury resolution
- 43% Reduction in cost

In-Person and Virtual Care Options – Choose Your Path to Recovery

In-Clinic Care

- 250+ locations in TX, WA, OH, and VA
- One full hour of one-on-one care
- Evidence-based manual therapy to eliminate pain and restore function
- Active care exercises to speed recovery

Virtual Care

- Connect remotely with an Airrosti provider for video consultations and guided prescriptions.
- Receive an Airrosti Remote Recovery Kit with tools to perform self-myofascial release and eliminate pain.
- Video check-ins and unlimited in-app messaging give you access to clinical support anywhere, anytime.

Call 800-404-6050 to begin your recovery plan.

Medical Benefits

Kaiser HMO Plan (California Only)

If you live in California, you also have the option to elect the Kaiser HMO Plan.

You must use in-network doctors to receive benefits. There are no out-of-network benefits except for urgent care and emergencies. You will have set copays for the services, and there is no deductible to meet. To find a provider, visit kp.org or call 800-464-4000.

	KAISER HMO IN-NETWORK ONLY
ANNUAL DEDUCTIBLE	
INDIVIDUAL	$0
FAMILY	$0
CALENDAR YEAR OUT-OF-POCKET MAXIMUM*	
INDIVIDUAL	$1,500
FAMILY	$3,000
WHAT YOU PAY	
PREVENTIVE CARE**	$0
OFFICE VISITS	$20 copay
EMERGENCY ROOM	$100 (waived if admitted); Ambulance $50 copay
X-RAYS AND LAB TEST	$0
INPATIENT HOSPITAL	$0
OUTPATIENT SURGERY	$20 copay

*Expenses that count toward meeting your out-of-pocket maximum include medical plan copays, prescription drug copays and coinsurance.

**Plan pays 100% for preventive care based on Kaiser's preventive care guidelines.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your monthly contributions.

MONTHLY CONTRIBUTIONS	CDHP		PPO PLAN 1		PPO PLAN 2	
	BIWEEKLY	SEMIMONTHLY	BIWEEKLY	SEMIMONTHLY	BIWEEKLY	SEMIMONTHLY
EMPLOYEE ONLY	$24.06	$26.07	$37.59	$40.73	$98.21	$106.40
EMPLOYEE + SPOUSE	$148.87	$161.28	$204.50	$221.55	$363.88	$394.21
EMPLOYEE + CHILD(REN)	$130.32	$141.19	$166.91	$180.82	$297.10	$321.86
EMPLOYEE + FAMILY	$200.50	$217.21	$280.69	$304.09	$496.96	$538.38

CONTRIBUTIONS	KAISER HMO	
	BIWEEKLY	SEMIMONTHLY
EMPLOYEE ONLY	$48.56	$52.61
EMPLOYEE + SPOUSE	$230.66	$249.88
EMPLOYEE + CHILD(REN)	$209.92	$227.41
EMPLOYEE + FAMILY	$314.62	$340.84

Note

Preventive care offered by an in-network physician, like well-woman exams or annual physicals, is often covered at 100%.

Tobacco Surcharge

If you use tobacco products (cigarettes, chew, and/or electronic cigarettes), you'll pay an additional $125 per month for your medical benefits. This surcharge will be waived if you enroll in a smoking cessation program. For more information on the smoking cessation program, contact Blue Cross Blue Shield at 866-412-8795.

Spousal Surcharge

If your spouse has other coverage available through his or her employer, and you enroll your spouse in a TEAM medical plan, you'll pay a spousal surcharge of $150 per month.

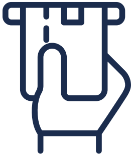
MDLive*

Talk to a doctor 24/7 from your computer, smartphone, or tablet. MDLive doctors can answer your questions, make a diagnosis, and prescribe basic medications (subject to availability by state). You and your covered family members can use this benefit if you're enrolled in a TEAM medical plan. For the CDHP, you'll pay 20% after the deductible. For the PPO plans, you'll pay a copay. To use MDLive, visit members.mdlive.com/bcbstx or call 888-680-8646.

*Available if enrolled in the BCBSTX CDHP or PPO

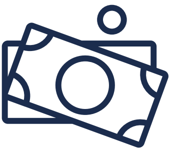
Out-of-Pocket Costs

These are the types of payments you're responsible for:



Copay

The fixed amount you pay for healthcare services at the time you receive them.



Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What about the COVID-19 vaccine?

The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through ExpressScripts (BCBSTX) and Kaiser. You may find information on our benefits coverage and search for network pharmacies by logging on to ExpressScripts: express-scripts.com/teaminc, kp.org for Kaiser, or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Formulary Brand, Non-Formulary Brand, or Specialty Drugs.

	CDHP	PPO PLAN 1	PPO PLAN 2
	IN-NETWORK	IN-NETWORK	IN-NETWORK
RX DEDUCTIBLE	Combined with Medical	$100	$100
RETAIL RX (30-DAY SUPPLY)			
GENERIC	20%*	$10	$10*
FORMULARY BRAND**	20%*	$40	$40*
NON-FORMULARY BRAND	20%*	$60	$60*
SPECIALTY DRUGS	20%*	$250	$250*
MAIL ORDER RX (90-DAY SUPPLY)			
GENERIC	20%*	$20	$20*
FORMULARY BRAND**	20%*	$80	$80*
NON-FORMULARY BRAND	20%*	$120	$120*
SPECIALTY DRUGS	20%*	$500	$500*

*After deductible

**The formulary drug list is updated annually, and medications may be added or removed. Before you fill a prescription, view the list or talk with your pharmacist to be sure you are getting a formulary brand or a generic option, if available.

You'll be allowed two 30-day fills of a maintenance medication from a retail pharmacy. After that, if you get a 30-day fill or use a non-preferred pharmacy, you'll have to pay the full retail cost.

	KAISER HMO (CALIFORNIA ONLY)
	IN-NETWORK ONLY
RX DEDUCTIBLE	None
RETAIL RX (30-DAY SUPPLY)	
GENERIC	$10
FORMULARY BRAND	$20
SPECIALTY	20% ($250 maximum)
MAIL ORDER RX (UP TO 100-DAY SUPPLY)	
GENERIC	$20
FORMULARY BRAND	$40

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps like GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. Make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. So if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a CDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a CDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

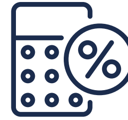
HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible Consumer-Driven Health Plan.
- You are not covered by your spouse's non-CDHP.
- Your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)



Tax-free Interest

Employer Contributions
(pre-tax)

Voluntary Contributions

HSA

Tax-free Payments
(for qualified medical expenses)

Note

Not sure how much to contribute? Think about how much you may need in order to cover any anticipated or emergency medical services this year. Consider contributing the amount of your plan's in-network deductible so you know you're covered.

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in TEAM's HSA, you must elect the CDHP with TEAM. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. TEAM will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2023, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$3,850
FAMILY	$7,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

TEAM provides an HSA employer contribution that will be deposited bi-annually (January and July). Employees must be enrolled at the time of the contribution to receive it.

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE ONLY OR EMPLOYEE + SPOUSE	$750
EMPLOYEE + CHILDREN OR FAMILY	$1,500

HSA contributions over the IRS annual contribution limits ($3,850 for individual coverage and $7,750 for family coverage for 2023) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The TEAM HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit hsabank.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $2,850 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact with reimbursement questions. If you need to submit a receipt, will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and submit an Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2023 plan year. (The Dependent Care FSA does have a grace period allowing you to use funds through March 15th of the following year.)
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to $610 may be rolled over to the next plan year at the end of 2023 for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Supplemental Health Benefits

TEAM offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident Coverage, available through MetLife, provides benefits for you and your covered family members if you have expenses related to an accidental injury. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and typical day to day expenses, such as a mortgage or car payment. Benefits under this plan are payable to you to use as you wish.

There's a health screening benefit too.* The plan will pay you $50 each year for one covered health screening, such as a physical exam, blood chemistry panel, or complete blood count (CBC).

*Health screening benefit not available in all states.

The Accident insurance plan pays cash benefits to help with costs associated with out of pocket expenses and bills in the event of a covered accident:

- Emergency treatment
- Hospital Admission
- Intensive care unit
- Ambulance transportation

2023 ACCIDENT RATES		
	EMPLOYEE BIWEEKLY	EMPLOYEE SEMIMONTHLY
EMPLOYEE ONLY	$4.18	$4.53
EMPLOYEE + SPOUSE	$8.37	$9.07
EMPLOYEE + CHILD(REN)	$9.87	$10.70
EMPLOYEE + FAMILY	$11.80	$12.78

Critical Illness Coverage

Critical Illness coverage through MetLife pays a lump sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. For example, to help pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Covered Benefits

(Paid at 100% of your elected benefit amount unless otherwise noted):

- Heart Attack
- Major Organ Failure
- Alzheimer's Disease
- Stroke
- Coma
- Coronary Artery Bypass (25%)
- Complete Blindness
- Invasive Cancer
- Complete Loss of Hearing
- Carcinoma in Situ (25%)
- Infectious Disease
- Skin Cancer (10%)
- Multiple Sclerosis
- Benign Brain Tumor
- Occupational HIV
- Parkinson's Disease
- Permanent Paralysis
- End Stage Renal Failure
- Amyotrophic Lateral Sclerosis (ALS)

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Employee: $10,000 or $20,000
  - Spouse: $10,000 or $20,000
  - Child(ren): $5,000 or $10,000
- Pre Existing Conditions: This plan does NOT have a pre existing condition exclusion. However, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.
- Wellness Benefit: A $100 wellness benefit is payable for each covered member for completing certain wellness screenings, such as a pap test, cholesterol test, mammogram, colonoscopy, or stress test ($25 benefit per child, max $100 for all children).
- Rates are based on your age and benefit amount and will be calculated for you when you go online for enrollment. Rates for this plan are grouped in five year increments and are subject to increase each time you enter a new age band.

2023 CRITICAL ILLNESS RATES

ATTAINED AGE	$10,000 BENEFIT			$20,000 BENEFIT		
	EMPLOYEE ONLY	SPOUSE	CHILD	EMPLOYEE ONLY	SPOUSE	CHILD
<25	$4.30	$4.30	$2.50	$8.60	$8.60	$5.00
25–29	$4.60	$4.70	$2.50	$9.20	$9.40	$5.00
30–34	$5.60	$5.80	$2.50	$11.20	$11.60	$5.00
35–39	$7.00	$7.20	$2.50	$14.00	$14.40	$5.00
40–44	$9.40	$9.80	$2.50	$18.80	$19.60	$5.00
45–49	$13.30	$13.40	$2.50	$26.60	$26.80	$5.00
50–54	$18.80	$17.80	$2.50	$37.60	$35.60	$5.00
55–59	$26.50	$23.80	$2.50	$53.00	$47.60	$5.00
60–64	$37.70	$32.70	$2.50	$75.40	$65.40	$5.00
65–69	$55.80	$44.80	$2.50	$111.60	$89.60	$5.00
70-74	$74.50	$61.00	$2.50	$149.00	$122.00	$5.00
75+	$98.30	$85.70	$2.50	$196.60	$171.40	$5.00

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. TEAM offers affordable plan options from BCBSTX for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit BCBSTX at bcbstx.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by BCBSTX for 2023.

	DENTAL	
CONTRIBUTIONS		
	BIWEEKLY	SEMIMONTHLY
EMPLOYEE ONLY	$12.78	$13.85
EMPLOYEE + SPOUSE	$26.95	$29.20
EMPLOYEE + CHILD(REN)	$32.20	$34.88
EMPLOYEE + FAMILY	$46.38	$50.25
	IN-NETWORK	
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$100	
FAMILY	$300	
ANNUAL MAXIMUM		
PER PERSON	$1,500	
COVERED SERVICES		
PREVENTIVE SERVICES** Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	$0, No deductible	
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	20%*	
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50%*	
ORTHODONTICS Dependent Child(ren) Only	50%*	

*After deductible. Out-of-network benefits are paid according to a "reasonable and customary" schedule. If you use an out-of-network dentist, you could receive an additional bill for the difference between what the plan pays and what the dentist charges.

**Routine exams, cleanings, and X-rays are two per calendar year.

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through BCBSTX (EyeMed).

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by BCBSTX (EyeMed) for 2023.

	VISION	
CONTRIBUTIONS		
	BIWEEKLY	SEMIMONTHLY
EMPLOYEE ONLY	$3.76	$4.08
EMPLOYEE + SPOUSE	$7.52	$8.15
EMPLOYEE + CHILD(REN)	$7.90	$8.56
EMPLOYEE + FAMILY	$11.00	$11.92

	IN-NETWORK	OUT-OF-NETWORK[1]	FREQUENCY
EXAMS			
COPAY	$10	All amounts over $40	Calendar year
LENSES[3]			
SINGLE VISION	$20 copay	All amounts over $40	Calendar year
BIFOCAL	$20 copay	All amounts over $60	
TRIFOCAL	$20 copay	All amounts over $80	
LENTICULAR	$20 copay	All amounts over $80	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	You get a 15% discount	No discount	Calendar year
ELECTIVE	$0, then all amounts over $150[4]	All amounts over $150	
MEDICALLY NECESSARY	$0 (must get prior approval)	All amounts over $210	
FRAMES			
COPAY	$0, then all amounts over $200[2]	All amounts over $45	Calendar Year

[1] When you use an out-of-network provider, you must pay the cost up front and file a claim to be reimbursed up to the out-of-network allowance.

[2] You get a 20% discount on all amounts over the plan allowance.

[3] The plan will pay 100% for polycarbonate lenses, scratch-resistant coating, UV coating, and tinting. There is an additional charge for some lens options such as some anti-reflective coatings, some progressive lenses, polarized lenses, and photochromic lenses.

[4] You get a 15% discount on all amounts over the plan allowance.

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

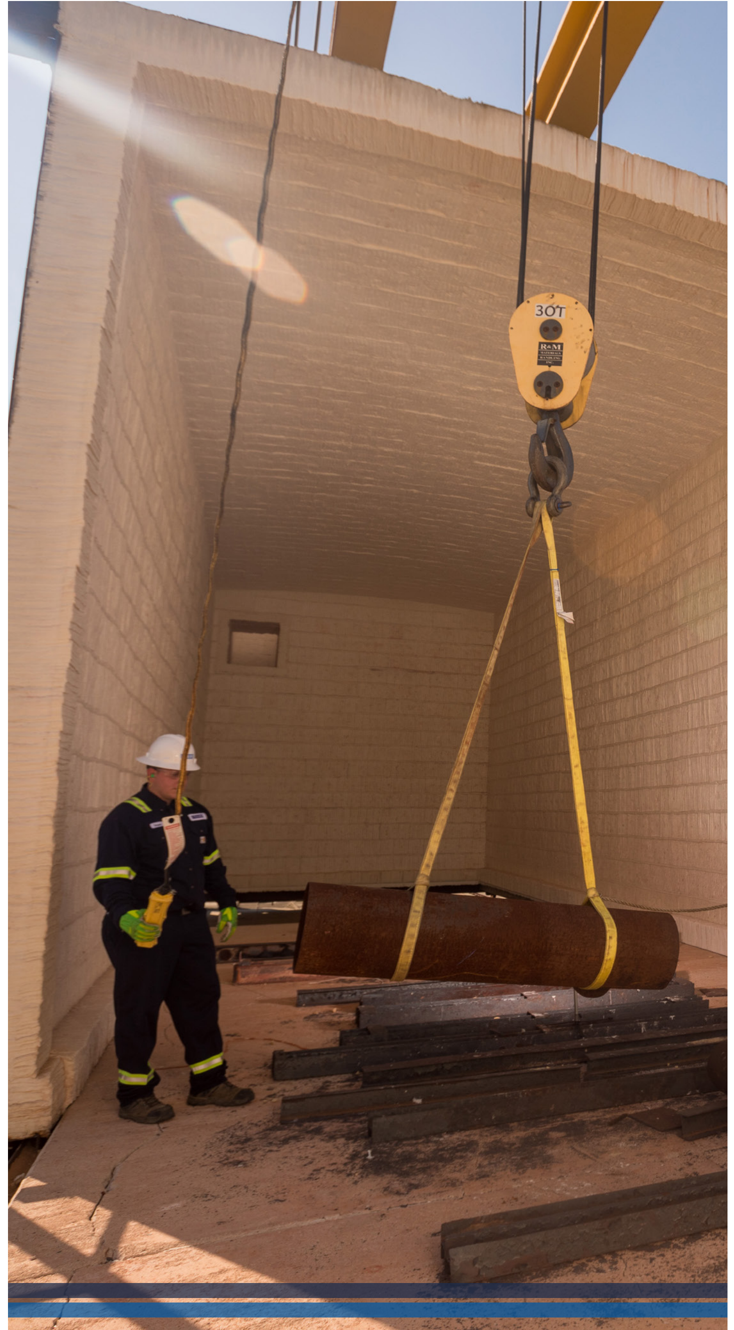
TEAM provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Lincoln Financial, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is 1x your annual earnings, up to $750,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the Lincoln Financial insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.



Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	1x your annual earnings
WHO PAYS	TEAM
BENEFITS PAYABLE	Upon death or accidental death and dismemberment of employee
MAXIMUM BENEFIT	Up to $750,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	Increments of $10,000 up to 4x your annual earnings
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death of employee
MAXIMUM BENEFIT	$750,000
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	$5,000 – $200,000; in increments of $5,000, up to 100% of employee's Voluntary Life insurance coverage
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death of spouse
MAXIMUM BENEFIT	$200,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death of child
MAXIMUM BENEFIT	$10,000
VOLUNTARY AD&D	
COVERAGE AMOUNT	Employee: $10,000 – $750,000, in increments of $10,000; amounts over $150,000 cannot exceed 10x your annual earnings For your family: Your spouse and children are covered as a percentage of your coverage. ▪ Spouse only: 100% of your coverage, up to $500,000 ▪ Children only: $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon accidental death and dismemberment of employee, spouse, or child

Evidence of Insurability (EOI) is a statement of health that insurance companies may require before insurance will be effective. If you are required to provide EOI, your enrollment must be approved by the insurer before your coverage is effective. As a new hire, you will need to provide EOI if you elect coverage above the guaranteed issue amount of $250,000 for yourself or $50,000 for your spouse. Increases up to the guaranteed issue amount as a result of a qualifying life event are permitted without EOI by our plan.

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (MONTHLY)			
AGE (AS OF JANUARY 1, 2023)	EMPLOYEE	AGE (AS OF JANUARY 1, 2023)	SPOUSE
<25	$0.06	<25	$0.04
25-29	$0.06	25-29	$0.04
30-34	$0.08	30-34	$0.05
35-39	$0.09	35-39	$0.07
40-44	$0.14	40-44	$0.09
45-49	$0.21	45-49	$0.13
50-54	$0.37	50-54	$0.20
55-59	$0.67	55-59	$0.30
60-64	$0.86	60-64	$0.51
65-69	$1.33	65-69	$0.86
70 and older	$2.06	70 and older	$1.47

Note: Rate changes when moving to a new age band will occur on your date of birth. The spouse rate is based on employee age.

VOLUNTARY CHILD LIFE INSURANCE

MONTHLY COST PER $10,000
$0.09

VOLUNTARY AD&D INSURANCE

MONTHLY COST PER $1,000
$0.025

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Income Protection

You and your loved ones depend on your regular income. That's why TEAM offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work.

Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

WEEKLY MAXIMUM BENEFIT	60%
ELIMINATION PERIOD	7 days for illness 1 day for accident
MAXIMUM BENEFIT PERIOD	26 weeks

Buy-Up Short Term Disability (STD) Insurance

Buy-Up Short Term Disability (STD) benefits are available for purchase on a voluntary basis. This insurance replaces 75% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

WEEKLY MAXIMUM BENEFIT	75%
ELIMINATION PERIOD	7 days for illness 1 day for accident
MAXIMUM BENEFIT PERIOD	26 weeks

Here's an example of what you would pay for STD Buy-Up if your base salary is $40,000.

- Basic STD Plan: Replaces 60% of $40,000 or $24,000
- STD Buy-Up Plan: Replaces 75% of $40,000 or $30,000
  - $30,000 – $24,000 = $6,000
  - $6,000 ÷ $10 = $600
  - $600 x $0.20 = $120 (annual cost)
  - $120 ÷ 26 pay periods = $4.62 biweekly cost

TEAM pays the full cost of Basic STD. You pay the cost if you elect STD Buy-Up. The cost is $0.20 per $10 of base salary. You pay the difference in percentage of income between Basic STD and STD Buy-Up. You'll see your cost for STD Buy-Up when you complete the online enrollment process.

How to Report a Claim

If you expect to be out of work for a short period of time due to an illness or injury, contact Lincoln Financial at 888-408-7300. A Lincoln Financial claim professional will verify your eligibility and start the claim process. You may also be able to take a Family and Medical Leave (FMLA) if your disability qualifies. FMLA provides up to 12 weeks in any 12 months of unpaid, job-protected leave for certain situations, such as the birth of a child or if you have a serious medical condition. To file a request for an FMLA leave, contact Lincoln Financial at 888-408-7300.

Retirement Planning

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Contributing to a 401(k) account now can help keep you financially secure later in life. The TEAM 401(k) plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	TEAM 401(k) Plan
RECORDKEEPER	Fidelity
WEBSITE	netbenefits.com
ELIGIBILITY	After you have been a full-time active employee for at least 30 days
COMPANY MATCH	TEAM helps you save by contributing a 50% match on up to 3% of your eligible earnings. For example, if you contribute 3%, TEAM will match 1.5%.
ENROLLMENT	You will become eligible to participate in the 401(k) plan and will automatically be enrolled in the plan after one month of service. If subject to automatic enrollment, Team will begin to deduct 6% from your pay on a pre-tax basis approximately 30 days after you are notified of your eligibility to participate in the plan unless you opt out by contacting Fidelity Investments. To opt out or change your 401(k) contribution, you may contact Fidelity Investments by calling 1-800-835-5097.

All About 401(k)

This employer-sponsored retirement account can help your future self by saving money — tax free — from your paycheck. The sooner you participate in a 401(k), the more time your assets have to grow.

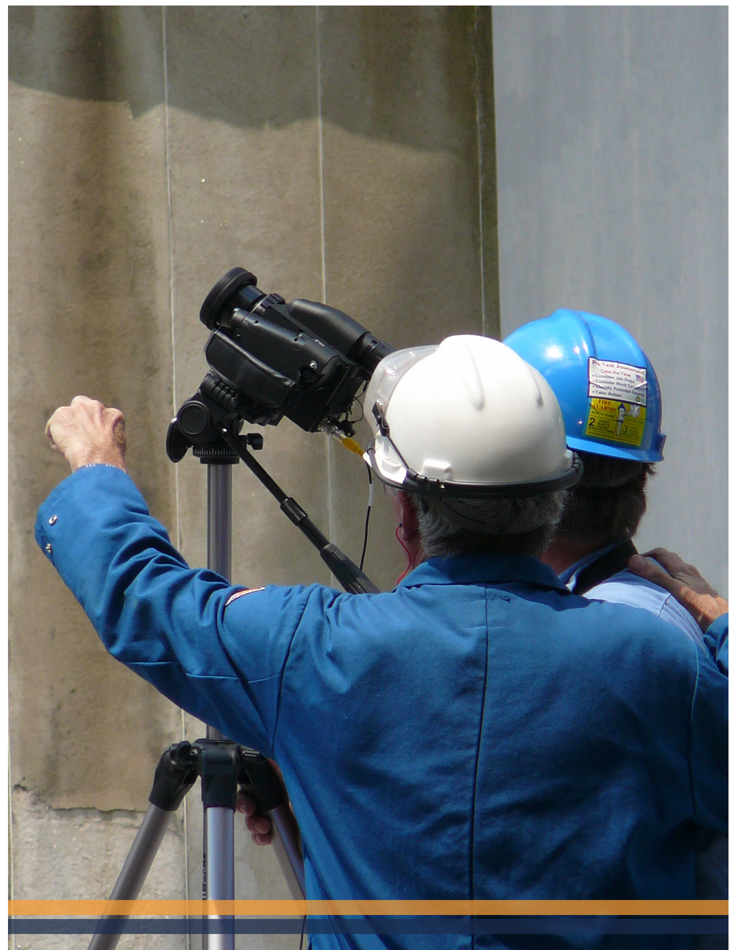
Eligible employees can invest for retirement while receiving tax advantages. TEAM helps you save by contributing a 50% match on up to 3% of your eligible earnings. For example, if you contribute 3%, TEAM will match 1.5%. Administrative services are provided by Fidelity. You may start making pre-tax contributions into the plan after you have been a full-time active employee for at least 30 days.

Pre-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions are taken out before taxes each pay period, which will lower your annual taxable income. Pre-tax contributions grow on a tax-deferred basis and you won't pay taxes on these dollars until a distribution is taken at retirement. If you choose the available Roth 401(k), contributions are deducted from your paycheck after taxes — so although you are paying taxes on those dollars now, you won't pay taxes when you withdraw during retirement.

Contributing to the Plan

The deferred contribution limit is set annually by the IRS.

If you are age 50 or older this year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in.



How Much Should I Save?

Industry standards suggest saving at least 12% to 15% of your income, including TEAM's matching contribution of a 50% match on up to 3% of your eligible earnings. If you can't afford to save that much, make sure to save up to the matching amount so you don't leave free money behind.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. Changes are effective as soon as administratively feasible and remain in effect until you modify them. You may also discontinue your contributions and start them again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact Fidelity at 800-835-5097 for details.

Regardless of which retirement account you choose or how much you contribute, remember to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and you may be subject to early withdrawal penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets. The TEAM 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, visit netbenefits.com.

Vesting

Vesting refers to how much of your 401(k) funds you can take with you if or when you leave TEAM. With our vesting schedule, each year you'll own a greater percentage of the company's matching contributions. When you're fully vested, you'll own 100% of the contributions. You always own and are fully vested in your own personal 401(k) contributions.

Note

The average American starts saving for retirement at age 27. But it's never too late! (Source: Annuity.org)

Additional Benefits

TEAM wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with TEAM. You may access information, benefits, educational materials, and more by phone at 866-248-4094 or online at liveandworkwell.com Access Code: TEAM.

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Perks at Work Discount Program

As a TEAM employee, you have access to the Perks at Work platform, which includes 30,000 national and local employee discounts on dinning, traveling, retail stores, and more. The site provides best-in-market pricing and ONECart technology to allow easy price comparison and seamless checkout. Log in, do your shopping, and get WOW points to redeem on future purchases. To get started, visits perksatwork.com.

Travel Assistance

TEAM offers global travel assistance through TravelConnect as part of your Basic Life Insurance benefits.

If you or your dependents have a medical emergency while traveling internationally or domestically more than 100 miles away from home, contact TravelConnect. You will get 24/7 access to doctors, hospitals, pharmacies, and other services.

For help, call **866-525-1955**. If you are outside the U.S. or Canada, call **+1-603-328-1955** (place a collect call). TravelConnect will help you find resources you need and even coordinate with your medical plan

Legal Coverage

You can purchase affordable Legal coverage through Hyatt Legal Plans. You will get full service on a variety of personal legal matters and access to attorneys in person, by phone, email, or mobile app.

The plan covers:

- Family law matters, such as adoptions and premarital agreements
- Estate planning service, such as living trusts and wills
- Traffic and criminal matters, including traffic tickets and juvenile court defense
- Financial services, such as debt collections defense and consumer protection
- Real estate issues, including boundary and title disputes.

You pay just $18.50 per month through convenient paycheck deductions. When you use a plan attorney for covered services, there are no deductions, copays, or claim forms.

Plus, when you enroll in Legal coverage, you automatically get credit monitoring from all three credit bureaus.

You can elect Legal coverage during Open Enrollment or within 60 days of your date of hire. Learn more at legalplans.com.

Home/Auto Insurance

Purchase Auto and Home Insurance through Farmers Insurance, and you can receive hundreds of dollars in savings, along with special group discounts:

- Save up to an additional 10% right away with the welcome discount for new members.
- Qualify for a group discount of up to 15% off your policy.
- Save more with the superior driver discount.
- Pay with convenient automatic deduction.
- Receive extra savings if you've been with your company a long time.
- Make the most of multi-policy savings when you insure both your home and auto with Farmers Auto & Home.

In addition to Auto and Home Insurance, Farmers Insurance offers a variety of other policies including boat, condo, renter's, motor home, and motorcycle.

Coverage is 100% portable, so even if you change jobs, you can take your policy with you.

Get a free quote by calling 800-438-6381.

SurgeryPlus™

The SurgeryPlus benefit is a supplemental benefit offered by TEAM for planned, non-emergency surgeries that provides a personalized concierge experience through a dedicated Care Advocate as well as access to quality care through a network of credentialed health care providers. By using the SurgeryPlus benefit, you may be able to save money through reduced financial responsibility.

When you call SurgeryPlus, a Care Advocate will help you find a surgeon that meets the rigorous SurgeryPlus credentialing standards, schedule your appointments, coordinate logistics, such as medical record transfers and any necessary travel arrangements, and ensure you have access to the best information as you make decisions about your care. Covered procedure categories include (but are not limited to) orthopedics, spine, general surgery, gynecology, ear nose and throat, GI, and cardiac and pain management.

You must be enrolled in one of the medical plans offered by Blue Cross Blue Shield of Texas to use this benefit. For more information and for the full list of available surgeries offered under the SurgeryPlus benefit, visit TeamInc.SurgeryPlus.com.

Glossary

Balance Billing – When you are billed by a provider 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 $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Consumer-Driven Health Plan (CDHP) – A plan option that provides choice, flexibility, and control over healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a CDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Important Contacts

Medical
Blue Cross Blue Shield of Texas (BCBSTX)
800-521-2227
bcbstx.com

Kaiser
800-464-4000
kp.org

Pharmacy
ExpressScripts
855-778-1495
express-scripts.com/teaminc

Kaiser
800-464-4000
kp.org

Supplemental Health (Accident, Critical Illness)
MetLife
800-438-6388

Telemedicine
MDLIVE
888-680-8646
members.mdlive.com/bcbstx

Dental
BCBSTX
800-521-2227
bcbstx.com

Vision
BCBSTX (EyeMed)
855-556-8796
eyemedvisioncare.com/bcbstxvis

Health Savings Account
HSA Bank
844-650-8936
hsabank.com

Flexible Spending Accounts
HSA Bank
844-650-8936
hsabank.com

Life and AD&D
Lincoln Financial
888-408-7300
MyLincolnPortal.com
Company Code: TEAM

Disability
Lincoln Financial
888-408-7300
MyLincolnPortal.com
Company Code: TEAM

Retirement
Fidelity
800-835-5097
netbenefits.com

Employee Assistance Program
Optum
866-248-4094
liveandworkwell.com
Access Code: TEAM

Home/Auto
Farmers Insurance 800-438-6381

Prepaid Legal Coverage
MetLife Legal Plans
legalplans.com

Travel Assistance
TravelConnect
Within the U.S. or Canada:
866-525-1955
Outside U.S. or Canada:
+1-603-328-1955

Cares on Site
833-209-7525 (option 1)

TEAM Human Resources
13131 Dairy Ashford Road, Ste. 600
Sugar Land, TX 77478
281-388-4090