TEAM®

2024
Benefit Guide

Contents

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 2024 benefits. Contact the Human Resources department with any questions.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal Law gives you choices about your prescription drug coverage. Please see page 35 for details.

What's Changing for 2024

- TEAM is moving from three plans with BCBSTX to two plans with Curative. Your coverage with Curative will be contingent upon the completion of a Base Line Visit within the first 120 days of coverage. Please review Page 7 of the guide carefully for plan details.
- Slight rate change for the two Curative plans.
- Short-Term Disability (STD) and Long-Term Disability (LTD) are moving to MetLife.
- Reintroducing a company paid LTD benefit and LTD Buy-up option through MetLife.
- Health Savings Account (HSA) is no longer offered.
- Now offering a Hospital Indemnity plan through MetLife.
- 2024 Annual Enrollment will be passive, except for the medical, FSA, and short term disability buy up plan.

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/pharmacy, 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 voluntary coverage.** You won't be able to enroll until the next Annual Enrollment unless you have a qualifying life event. If you elect benefits or make changes during the Annual Enrollment Period, your new coverage will begin on January 1.

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.

Note

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

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 Annual 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.

Questions?

Call the NEW Gallagher Benefit Advocate Center (BAC) at **833-295-9078** or email **bac.team@ajg.com**.

Hours of operation: Monday – Friday | 8 a.m. – 6 p.m.

Preparing for Enrollment

TEAM covers a significant amount of your benefit costs. Your contributions for medical/pharmacy, 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 you share of the premium.

Enrollment Action Items

Enroll in your medical plan.

Most of your 2023 enrollments will carry over to 2024 but you will still need to choose your medical plan. Please review the new medical plans carefully and choose the plan that best fits your needs.

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. Make sure to also populate or update your beneficiary information.

If you select a Curative Medical Plan, sign up for your Baseline visit.

If you do not participate in a Baseline visit in the first 120 days of the year, you will be subject to higher medical costs and you will miss out on a $0 deductible. Please see page 7 for more details.

Consider your FSA.

An FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding an FSA account 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.

Medical Benefits

Medical benefits are provided through Curative 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 2024 plan year unless you have a qualifying life event.

How to Find a Provider

Visit **https://curative.com/teaminc** or call Customer Care at **855-428-7284** for a list of Curative network providers.

You have the option to choose from 2 medical plans administered by Curative

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

PPO Plan	EPO Plan

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 EPO (Exclusive Provider Organization) work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You must use healthcare providers within the plan's network, except in cases of emergency or urgent care.

What Is A Baseline Visit?

A Baseline Visit is an opportunity for employees' to meet their designated Care Navigator and a clinician to jump-start their health and wellness journey. You will be oriented to the plan, connected to wellness programs and be given the time to get any health questions answered. Visits are done virtually from the comfort of your home. To schedule a baseline visit, go to **curative.com/baseline**.

Medical Plan Summary

This chart summarizes the 2024 medical coverage provided by Curative. The below benefits are for both the PPO and EPO plans **EXCEPT** out-of-network benefits are not covered under the EPO Plan. 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.

	In-Network With Baseline Visit	In-Network Without Baseline Visit	Out-of-Network**
ANNUAL DEDUCTIBLE			
INDIVIDUAL	$0	$5,000	$10,000
FAMILY	$0	$10,000	$20,000
COINSURANCE (YOU PAY)	0%*	20%*	50%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)[3]			
INDIVIDUAL	$0	$7,500	$15,000
FAMILY	$0	$15,000	$30,000
COPAYS / COINSURANCE			
PREVENTIVE CARE	No charge	No charge	$50 copay
PRIMARY CARE	$0	$25*	$50*
VIRTUAL VISITS	$0	$0	Not Covered
SPECIALTY CARE	$0	$50*	$100*
EMERGENCY ROOM[2]	$0	20%*	80%*
URGENT CARE	$0	20%*	50%*
INPATIENT HOSPITAL[1]	$0	20%*	50%*
OUTPATIENT SURGERY	$0	20%*	50%*

*After deductible

**Out-of-network benefits are NOT covered under the EPO Plan.

[1]Inpatient Hospital: Pre-certification required.

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

[3]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.

IMPORTANT: A Baseline visit must be completed within 120 days after the start of the plan year to receive $0 copay and 0% coinsurance benefits.

To schedule a baseline visit, go to **curative.com/baseline**.

Airrosti

Airrosti provides highly effective, personalized care for acute and chronic musculoskeletal pain and conditions. Curative members are able to access Airrosti at no charge with the baseline visit. 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 / Pharmacy Premiums

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

	Curative PPO Plan		Curative EPO Plan	
MONTHLY CONTRIBUTIONS				
	BIWEEKLY	**MONTHLY**	**BIWEEKLY**	**MONTHLY**
EMPLOYEE ONLY	$69.43	$150.44	$25.00	$54.16
EMPLOYEE + SPOUSE	$253.32	$548.87	$160.00	$346.66
EMPLOYEE + CHILD(REN)	$226.11	$489.90	$140.00	$303.33
EMPLOYEE + FAMILY	$358.38	$776.49	$215.00	$465.83

	KAISER HMO	
CONTRIBUTIONS		
	BIWEEKLY	**MONTHLY**
EMPLOYEE ONLY	$55.28	$119.78
EMPLOYEE + SPOUSE	$262.59	$568.94
EMPLOYEE + CHILD(REN)	$238.98	$517.78
EMPLOYEE + FAMILY	$358.18	$776.05

Virtual Care

Talk to a doctor 24/7 from your computer, smartphone, or tablet. Virtual Care 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 PPO plans, you'll pay a copay. If you are located in Texas, you will utilize Norman MD and if you are located anywhere else in the country, you will use Teladoc.

For more information, please access your Curative portal or call Curative to help set up care at 512-421-5678.

*Available if enrolled in either medical plan

Note

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

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:

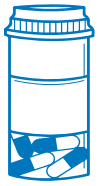
Wellness visits, physicals, and standard immunizations

Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Iron supplements (for children ages 6 to 12 months at risk for anemia)



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 and 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**** • Can require a copay and/or coinsurance • Normally requires an appointment • Usually little wait time with scheduled appointment

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.

Urgent Care Center	Emergency Room
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.	**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* • Strains, sprains • Minor broken bones (e.g., finger) • Minor infections • Minor burns • X-rays	**Types of Care*** • Heavy bleeding • Chest pain • Major burns • Spinal injuries • Severe head injury • Broken bones
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)	**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

*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 Curative and Kaiser. You may find information on our benefits coverage and search for network pharmacies by logging on to Curative: **curative.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.

	Curative In-Network With Baseline Visit	Curative In-Network Without Baseline Visit	Curative Out-of-Network
	IN-NETWORK	IN-NETWORK	IN-NETWORK
RETAIL RX (30-DAY SUPPLY)			
GENERIC	$0	$50*	50%*
FORMULARY BRAND**	$0	$50*	50%*
NON-FORMULARY BRAND	$50	$100*	50%*
SPECIALTY DRUGS	$250	25%*	50%*
MAIL ORDER RX (90-DAY SUPPLY)			
GENERIC	$0	$50*	50%*
FORMULARY BRAND**	$0	$50*	50%*
NON-FORMULARY BRAND	$50	$100*	50%*
SPECIALTY DRUGS	$250	25%*	50%*

*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.

	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.

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 $3,050 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.

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 FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- 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 2024 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.

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 off-the-job accident. 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, such as:

- Emergency treatment
- Hospital Admission
- Intensive care unit
- Ambulance transportation
- Fracture, dislocation, burn, concussion, coma

2024 ACCIDENT RATES		
	EMPLOYEE BIWEEKLY	EMPLOYEE MONTHLY
EMPLOYEE ONLY	$4.55	$9.85
EMPLOYEE + SPOUSE	$9.09	$19.70
EMPLOYEE + CHILD(REN)	$10.36	$22.45
EMPLOYEE + FAMILY	$12.82	$27.77

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 in the plan summary):

- 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): $10,000 or $20,000
- **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.

2024 MONTHLY 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

Hospital Indemnity Insurance

Your health insurance covers many costs of your stay and treatment. But you still have a lot of expenses, including deductibles, copays and other costs you couldn't predict. MetLife will send a check directly to you — not to your medical providers — upon approval of your claim. You decide how you spend the money.

Key Advantages:

- Pays your directly – so you can decide what to spend the cash on
- Covers hospitalization due to pregnancy, injury and illness – including COVID or a mental health condition

2024 HOSPITAL INDEMNITY RATES		
	EMPLOYEE BIWEEKLY	EMPLOYEE MONTHLY
EMPLOYEE ONLY	$8.77	$19.00
EMPLOYEE + SPOUSE	$17.24	$37.35
EMPLOYEE + CHILD(REN)	$10.25	$22.21
EMPLOYEE + FAMILY	$21.79	$47.22

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 2024.

CONTRIBUTIONS		
	BIWEEKLY	MONTHLY
EMPLOYEE ONLY	$12.78	$27.69
EMPLOYEE + SPOUSE	$26.95	$58.40
EMPLOYEE + CHILD(REN)	$32.20	$69.76
EMPLOYEE + FAMILY	$46.38	$100.49
	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.

CONTRIBUTIONS		
	BIWEEKLY	Monthly
EMPLOYEE ONLY	$3.76	$8.15
EMPLOYEE + SPOUSE	$7.52	$16.30
EMPLOYEE + CHILD(REN)	$7.90	$17.12
EMPLOYEE + FAMILY	$11.00	$23.84

	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 Group, 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 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: $5,000 – $500,000, in increments of $5,000. 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, 2024)	EMPLOYEE	AGE (AS OF JANUARY 1, 2024)	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 illness or injury. A portion of your income is protected until you can return to work or you reach retirement age.

Basic 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.

Long Term Disability (STD) Insurance

Long Term Disability (LTD) benefits are available at no cost. This insurance replaces 40% 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.

Hourly Employees

WEEKLY MAXIMUM BENEFIT	$5,000
ELIMINATION PERIOD	180 Days

Salary Employees

WEEKLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	180 Days

Buy-Up Long Term Disability (LTD) Insurance

Buy-Up Long Term Disability (LTD) benefits are available for purchase on a voluntary basis. 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.

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 MetLife at **833-622-0135**. A MetLife 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 MetLife at **833-622-0135.**

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, part-time, and full-time temporary active employee for at least 30 days. Regular part-time and full-time temporary employees are also eligible
COMPANY MATCH	TEAM helps you save by contributing a 50% match on up to 6% of your eligible earnings. For example, if you contribute 6%, TEAM will match 3%.
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 **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 6% of your eligible earnings. For example, if you contribute 6%, TEAM will match 3%. 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 6% 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 (EAP)

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 Annual Enrollment or within 60 days of your date of hire. Learn more at **legalplans.com**.

Gallagher Marketplace

TEAM will begin to offer Gallagher Marketplace for all employees. Gallagher marketplace offers benefits to employees such as home and auto insurance, renters insurance, extended vehicle warranties, as well as boat, ATV and RV coverage. You can view multiple quotes side-by-side so you may choose the best option suited for your needs. You do not have to enroll during annual enrollment, you may enroll anytime.

Gallagher Enrollment Solutions

(One-on-one enrollment counselor will walk your through all of your benefit options)

- Schedule online at PENDING
- Scan the QR code with your phone's camera

Self-enroll by following the on-screen instructions:

- Click "Select" to choose your plans. Track your choices and costs as you make your elections.
- Click "Approve" to submit your elections.

Confirm and print your elections confirmation.

Benefit Advocate Center

The TEAM Benefit Advocate Center (BAC) is a great resource available to TEAM employees both during the annual enrollment period and anytime you like throughout the year. The BAC is a group of specialists who are available to assist you and your family members with questions about your benefit plans, claims issue resolution, and more. They can be reached by either calling 833.940.3909 during operating hours (8:00 a.m. to 6 p.m. CT) or emailing bac.teaminc@ajg.com.

Glossary

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

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.

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.

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.

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 Notices

Women's Health & 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 the plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please call your Plan Administrator at Human Resources 281-388-4090.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Regarding Wellness Program

The TEAM wellness program is a voluntary wellness program available to all employees enrolled in a TEAM Curative medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test for Cholesterol, A1C, and others. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive incentives per the program guidelines for participating in various activities. Although you are not required to complete the HRA or participate in the biometric screening, coaching, or other activities, only employees who do so will receive the associated incentives.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HR.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as educational information or coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Freeman may use aggregate information it collects to design a program based on identified health risks in the workplace, Freeman wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Curative health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HR.

Patient Protections Disclosure

The TEAM Plan 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 a list of participating primary care providers, contact Curative at the number listed on the back of your ID card or at **curative.com**.

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

You do not need prior authorization from TEAM or Curative 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 Curative at the number listed on the back of your ID card or at **curative.com**.

SMM/SMR

This summary of material modification (“SMM”) and summary of material reduction (“SMR”) describes changes to the TEAM Group Health Benefit (“Plan”) and supplements the Summary Plan Description (“SPD”) for the Plan. The effective date of each of these changes is January 1, 2024 unless otherwise indicated. You should read this SMM/SMR very carefully and retain this document with your copy of the SPD for future reference.

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 **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 **866.444.EBSA (3272).**

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

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

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

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

Notice of Creditable Coverage

Important Notice from TEAM, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with TEAM, Inc. 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. **TEAM, Inc. has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current **TEAM, Inc.** coverage will not be affected. "For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

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

You should also know that if you drop or lose your current coverage with **TEAM, Inc.** 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 **TEAM, Inc.** changes. You also may request a copy of this notice at any time.

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

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

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 **www.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:	October 15, 2023
Name of Entity/Sender:	TEAM, Inc.
Contact:	Human Resources
Address:	13131 Dairy Ashford Road, Suite 600 Sugar Land, TX 77478
Phone Number:	281-388-4090 (option 1)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

TEAM, Inc. is committed to the privacy of your health information. The administrators of the TEAM, Inc. Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 281-388-4090.

HIPAA Special Enrollment Rights

TEAM, Inc. Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the TEAM, Inc. Health Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact:

Human Resources
13131 Dairy Ashford Road, Suite 600
Sugar Land, TX 77478
281-338-4090 (option 1)

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

1 **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

TEAM, Inc. Health Plan
Human Resources
13131 Dairy Ashford Road, Suite 600
Sugar Land, TX 77478
281-388-4090 (option 1)

Important Contacts

Medical

Curative
855-428-7284
curative.com

Kaiser
800-464-4000
kp.org

Pharmacy

Curative
855-428-7284
curative.com

Kaiser
800-464-4000
kp.org

Supplemental Health (Accident, Critical Illness, Hospital Indemnity)

MetLife
800-438-6388

Dental

BCBSTX
800-521-2227
bcbstx.com

Vision

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

Healthcare Flexible Spending Accounts

HSA Bank
844-650-8936
hsabank.com

Life and AD&D

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

Disability

MetLife
833-622-0135

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

TEAM

Human Resources
13131 Dairy Ashford Road, Ste. 600
Sugar Land, TX 77478
281-388-4090 (option 1)

Benefit Advocate Center (BAC)

833-295-9078
email to: bac.team@ajg.com
Hours of operation:
Monday – Friday 8 a.m. – 6 p.m.

Notes

Notes

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN24BGTM