TEAM

2027

# BENEFITS GUIDE

Support for your physical, financial, and personal wellbeing.

# 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 2027 benefits. Contact the Human Resources department with any questions.

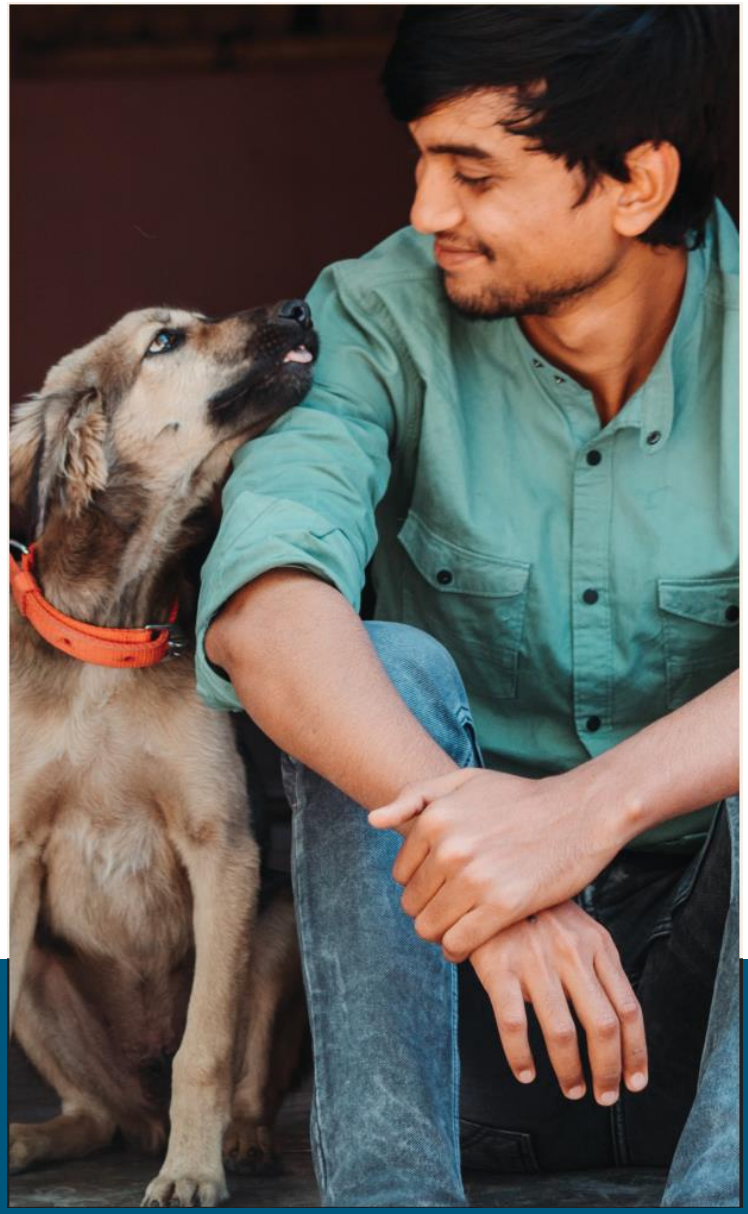

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**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal Law gives you choices about your prescription drug coverage. Please see page 49 for details.**

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

# WHAT'S CHANGING FOR 2027

- Changing rates and Medical plans from Curative to BCBSTX.
- Slight rate change to Kaiser medical plans.
- Moving to UNUM for Life/AD&D, Disability and Voluntary Benefits
- 2027 Annual Enrollment will be **ACTIVE** for the medical insurance. You must enroll in medical insurance to have coverage for 2027.



# ENROLLMENT

Eligibility, enrollment, and preparing for the plan year

2027 BENEFITS GUIDE

# 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 from 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
- 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 UKG 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 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

**Update your personal information.**

If you've experienced any life changes since the last Annual 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 BCBSTX Plan with The Difference Card.**

If you enroll in a BCBSTX medical plan, you will also be enrolled in The Difference Card which will help offset first dollar medical costs. Please see pages 9-14 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.



# PHYSICAL WELLBEING

Medical, pharmacy, dental, and vision benefits

2027 BENEFITS GUIDE

# MEDICAL BENEFITS

Medical benefits are provided through BlueCross BlueShield of Texas (BCBSTX) and Kaiser. Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2027 plan year unless you have a qualifying life event.

## How to Find a Provider

Visit **bcbstx.com** or call Customer Care at **800.521.2227** for a list of BCBSTX network providers.

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

*If you live in California, you will also have the option of an HMO plan through Kaiser. Visit **kp.org** to find network providers..*

| Base Plan | Buy Up 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.

**Base vs Buy Up Plan**

- You'll pay more in premiums for the Buy Up plan, but you will have more of your medical costs paid for by the Difference Card
- Under both plans, you will have access to the same network of providers.
- If you expect to need more medical care this year or you have a chronic illness, the Buy Up plan may be the best option.

## What Is The Difference Card?

The Difference Card, also known as a MERP, is an employer-funded benefit that helps pay employees' out-of-pocket Medical costs. TEAM establishes a fixed budget to help cover eligible expenses as defined by the BCBSTX medical plan. Employees go to the doctor, fill prescriptions and incur costs as usual. Once an eligible expense occurs, MERP pays out in two ways:

1. Mastercard – Employees use a pre-funded card to pay for expenses
2. Reimbursement – Employee submits the claim and is reimbursed by The Difference Card

**Better Benefits at a Better Price**

- Employees pay less out-of-pocket.
- Employers control costs and avoid surprises.
- Product backed by an A rated division of Assurant.
- Potential savings for employees and employers.

# MEDICAL PLAN SUMMARY

This chart summarizes the 2027 medical coverage provided by BCBSTX with The Difference Card. The below benefits show the base and buy up BCBSTX medical plans . 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. **Baseline visits are no longer required under the BCBSTX medical plan options.**

| | BCBSTX Medical Plan<br>NOT AN OPTION<br>(For Reference) | In-Network*<br>BASE PLAN w/Difference Card | In-Network*<br>BUY UP PLAN w/Difference Card |
|---|---|---|---|
| **ANNUAL DEDUCTIBLE** | | | |
| INDIVIDUAL | $7,500 | $3,000 | $1,500 |
| FAMILY | $15,000 | $6,000 | $3,000 |
| COINSURANCE (YOU PAY) | 0%* | 0%* | 0%* |
| **ANNUAL OUT-OF-POCKET MAXIMUM (maximum includes deductible)[3]** | | | |
| INDIVIDUAL | $7,500 | $3,000 | $1,500 |
| FAMILY | $15,000 | $6,000 | $3,000 |
| **COPAYS / COINSURANCE** | | | |
| PREVENTIVE CARE | No charge | No charge | No charge |
| PRIMARY CARE | 0% after Ded | Difference Card pays first $4,500/$9,000; employee pays remaining $3,000/$6,000 deductible; then covered 100% | Difference Card pays first $6,000/$12,000; employee pays remaining $1,500/$3,000 deductible; then covered 100% |
| VIRTUAL VISITS | 0% after Ded | | |
| SPECIALTY CARE | 0% after Ded | | |
| EMERGENCY ROOM[2] | 0% after Ded | | |
| URGENT CARE | 0% after Ded | | |
| INPATIENT HOSPITAL[1] | 0% after Ded | | |
| OUTPATIENT SURGERY | 0% after Ded | | |

*Out-of-network benefits are NOT shown under this summary. Please reference the SBC found at **teamincbenefits.com**.

[1]*Inpatient Hospital: Pre-certification required.*

[2]*Care Coordination must be notified within two days. Coverage for true emergencies only.* Care coordination helps members access appropriate care and resources. Members should contact the carrier before certain services, admissions, or procedures when notification is required.

[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: The Difference Card pays only toward claims the medical carrier recognizes as as eligible under the medical plan and that are included in your employer funded benefit.

For questions about how to use your Difference Card, please refer to your Member Welcome Kit or call the Customer Care TEAM at **888.343.2110**.

Using your smart phone's camera, scan this to download the mobile app.

# MEDICAL BENEFITS

## NEW! The Difference Card

The Difference Card is a debit card funded by TEAM that helps you save money on your Medical and Pharmacy expenses. All BCBSTX medical plan enrollees will receive a Difference Card MasterCard via mail.

When accessing care through your BCBSTX medical plan, you will use your Difference Card dollars to help cover the cost of healthcare services, including pharmacy. For some services, you will swipe the Difference Card MasterCard to cover your co-pay at the time of your visit. For other services such as imaging, hospital stays, surgeries, and emergency room visits, you will receive a bill from your provider after your Medical insurance has been applied. You can send this bill to Difference Card who will pay for a majority of the cost of the service. Any remaining amount owed is your out-of-pocket responsibility.

TEAM provides a set amount of dollars in your Difference Card account that you and your covered dependents may utilize throughout the year. Once you use all of those dollars, you will be responsible for any additional medical costs until you hit your plan's out of pocket maximum. **Once that is met, the insurance carrier will cover the rest of your medical expenses 100% until the end of the calendar year (December 31).**

The Difference Card



# THE DIFFERENCE CARD IN ACTION




## Difference Card MasterCard

Misplace your card? Request a replacement by calling Difference Card at 888.343.2110. You may also pay out of pocket for your medical or pharmacy services and submit a claim through the mobile app to be reimbursed.



**1.** When visiting his primary care doctor, Danny presents his Medical Insurance Card first.




**2.** The doctor's office tells Danny the co-pay amount due for the visit.




**3.** Danny swipes his Difference Card debit card first. If he has enough funds available, then it will cover his entire cost. If he has used up all of his funds, he will be asked to pay the difference owed.




**4.** The total amount due for the office visit is now paid!

**NOTE: The Difference Card may require claims substantiation for claims over a certain dollar amount. Maintain billings and receipt records for substantiation requests.**

The Difference Card

## THE DIFFERENCE CARD IN ACTION

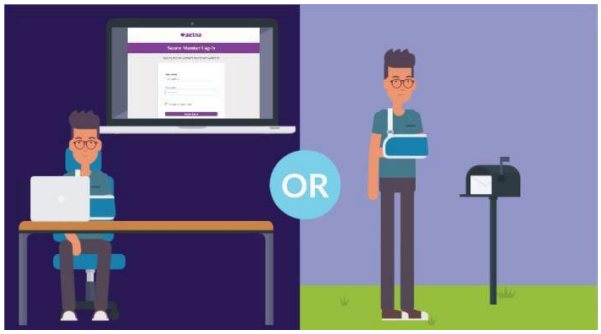
For services such as imaging, hospital stays, surgeries, and emergency room visits, you will receive a bill from your provider after your BCBSTX insurance has been applied. You can send this bill to Difference Card who will pay for a majority of the cost of the service. Any remaining amount owed is your out-of-pocket responsibility.



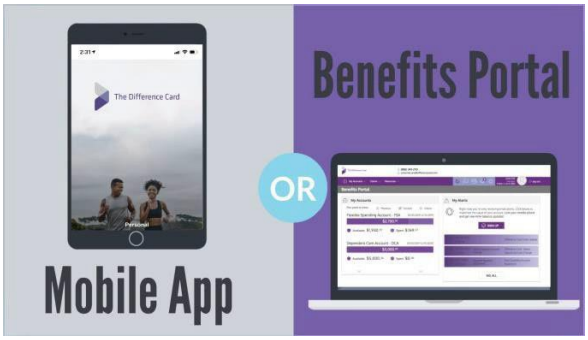
**1.** While at the Emergency Room, Danny is not charged at the time of his visit because this service applies to his plan deductible.




**2.** Instead, Danny will present his Medical Insurance Card to the provider who will bill Danny's insurance for the visit and any services.




**3.** Danny will get a bill from the provider and an insurance statement* in the mail. He may also obtain his insurance statement online through the insurance carrier member website.

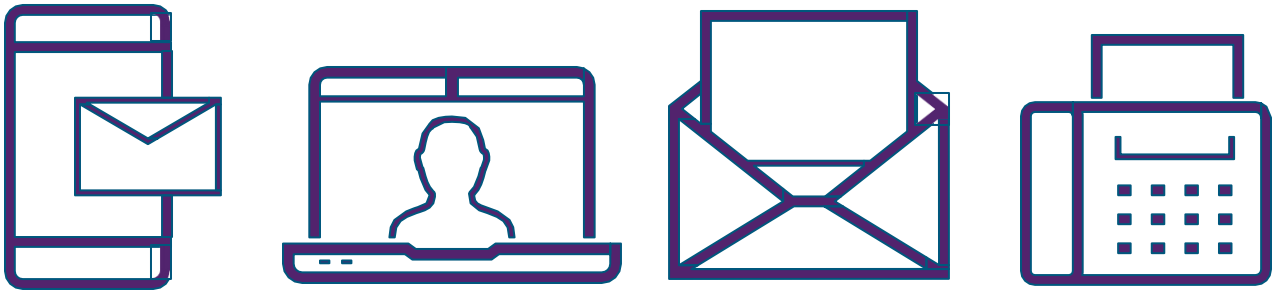



**4.** Danny will submit a claim to Difference Card, who will issue a reimbursement payment to Danny. The remaining balance is Danny's out of pocket responsibility. **TIP**: If enrolled, you may use your Flexible Spending Account (FSA) dollars to cover your out-of-pocket costs!

**An Insurance Statement (sometimes called an Explanation of Benefits (EOB)), describes what costs your Insurance Provider will cover for medical care.*

**NOTE: The Difference Card may require claims substantiation for claims over a certain dollar amount. Maintain billings and receipt records for substantiation requests.**

The Difference Card



## MOBILE

Download the **Difference Card Smart Mobile** app to submit your claim with a picture.

## ONLINE

Log in to your account at **differencecard.com** to submit your claim online.

## MAIL

Fill out a Reimbursement Form and submit your documents via mail to **245 Main Street, Suite 605, White Plains, NY 10601**.

## FAX

Fill out a Reimbursement Form and submit your documents via fax to **914.220.0901**.




## DIRECT DEPOSIT

*The fastest way to get your money.*

Money will come back to you via direct deposit if you select that as your Reimbursement Preference.

## TOOLS ON THE GO

*Use with your smartphone or tablet.*

Scan this code with your camera app to get helpful resources at your fingertips!

SCAN ME

### Difference Card Customer Care Team

Monday – Friday
5AM – 6PM PST
Phone: (888) 343-2110
**differencecard.com**

*Log into your account to chat with a representative.*

The Difference Card

# ADDITIONAL BCBSTX PROGRAMS

Taking one, small, first step can set you on a path to better health throughout your life. Whether you need support for a specific health issue of you're looking to boost your overall wellbeing, you'll have help along the way. Here are a few of the tools included with your health plan.

## Fitness Program

As a BCBSTX member, the Fitness Program is available exclusively to you and your covered dependents (age 16 and older). The program gives you access to a nationwide Network of fitness locations. Choose a location close to home and near work. You can also visit locations while traveling.

**Perks and Features include:**

- Flexible Gym Network: Choice of networks to fit your budget and preferences.
- Family Friendly: Expands gym network access to your covered dependents at a bundled price discount.
- Convenient Payment: Monthly fees are paid via automatic credit card or bank account withdrawals.
- Mobile App: Allows members to access location search, location check-in and activity history.
- Digital Fitness: Stay active from the comfort of your home access thousands of digital fitness videos and live classes including cardio, bootcamp, barre, yoga and more.

Register through **bcbstx.com** and login to Blue Access for members. Select the My Health tab, then Wellness at the top of the Dashboard page. Scroll down to Fitness Program. You can also sign up by calling **888.762.2583**.

## Wondr

Weight loss isn't one-size-fits-all. Meet Wondr, the wight-loss program that has content tailored to you. Wondr is a skill-based digital weight-loss program that teaches you how to lose weight, increase your energy and improve your sleep, while eating the foods you love. This program is based on behavioral Science and takes a personalized approach that fits into your life at no cost to you.

Employees, spouses and covered dependents age 18 and over, Enrolled in the BCBSTX medical plan, are eligible to apply to the the program. Get started today at **wonderhealth.com/BCBSTX**.

## Mental Health Hub

With the Mental Health Hub, you have direct access to Specialized care and the following mental health providers:

- Equip: Eating disorders
- Manatee and Charlie Health: Pediatric mental health
- NOCD: Obsessive-compulsive disorders
- Workit Health: Substance use disorders

**Mental Health Hub is confidential and available 24/7**
Visit **bcbstx.crediblemind.com/mentalhealthhub** to explore.

## Learn to Live

Take care of your mental health with Learn to Live programs and assessments. You can learn new skills and get support for breaking old patterns that may be holding you back. These programs are available 24/7 at no extra cost for you and your dependent children (ages 13 and up). To get started visit learntolive.com/BCBSTX and use access code BETTERME.

## Teladoc Health

Discover tools and techniques that work for you. Get an advanced blood pressure monitor, blood glucose meter and as many lancets as you need. You can also get one-on-one coaching with guidance on building healthy habits.

Get started now. Join by visiting **TeledocHealth.com/Now** or call **800.835.2362**.

## Omada (Hypertension)

Omada is virtual care for real life. This program supports people in managing their health conditions. Omada helps members with hypertension reduce their risk of heart disease by providing support that's timely, coordinated, and at your own pace. The goal is to provide achievable plans to have lasting change.

BCBSTX will reach out to members and confirm eligibility of the program.

## Omada (Prevention & Weight Health)

Omada for Prevention & Weight Health helps members achieve And maintain their goal weight with behavior change tools and a real coach in their corner. You will also have a dedicated Care team and supportive tools and resources.

BCBSTX will reach out to members and confirm eligibility of the program.

# ADDITIONAL BCBSTX PROGRAMS

## Airrosti

Airrosti provides highly effective, personalized care for acute and chronic musculoskeletal pain and conditions. As a BCBSTX member, you have the Flex program, a premier digital app that that has self-guided movement and exercise programs designed to help reduce your pain, enhance mobility and reach your overall wellness goals.

Flex evaluates your muscle and joint health with precision Delivering an on-demand exercise program customized just for you. Enroll in Flex to build your personalized plan that you can access from home, at your convenience.

This member wellness benefit is available at no cost to you.

### Move On Your Schedule

- **Personalized Plan.** After you complete the FlexCheck Movement assessment, Flex creates a customized Program tailored to your needs that consists of easy-to-follow mobility and stability exercises.
- **Optional Health Coach.** When extra support is needed you can choose to access a team of Certified Health whether you have a quick question or need to modify your program, you can message a health coach or get on a video call.
- **Flex Kit Delivered to Your Home.** The Flex Kit is a curated collection of rehab tools delivered straight to your front door at no additional cost. The kit may include a variety of essential wellness tools to help you recover faster, including a foam roller, resistance bands, a massage stick and more.

### Proven Results

Flex is powered by Airrosti, a national leader in musculo-skeletal care with over 20 years of clinical practice. Their experience ensures that you benefit from the expertise that has brought lasting pain relief to over one million patient cases.

### Start Moving Today!

Scan the QR code below or visit **https://flexbyairrosti.com** to learn more and enroll today.

## Hinge Health

Hinge Health proudly offers highly effective pain care that gets you moving. Relieve joint and muscle pain with personalized exercise at no cost to you. On average, participants reduce their pain by 68%. With Hinge Health you get:

- Virtual sessions anytime, anywhere
- Unlimited 1-on-1 health coaching
- Motion tracking technology for instant form correction

Hinge Health will reach out to eligible members with program details and next steps.

## Connect to Care

Use the Connect to Care portal to review helpful content about your condition, set health goals or chat with a care team for extra support. You may be eligible if you have certain health conditions, such as diabetes, high blood pressure or asthma. You'll receive either a call from a nurse or a message from BCBSTX if you qualify.



# 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<br>IN-NETWORK ONLY |
|---|---|
| **ANNUAL DEDUCTIBLE** | |
| INDIVIDUAL | $0 |
| FAMILY | $0 |
| **CALENDAR YEAR OUT-OF-POCKET MAXIMUM*** | |
| INDIVIDUAL | $2,000 |
| FAMILY | $4,000 |
| **WHAT YOU PAY** | |
| PREVENTIVE CARE** | $0 |
| OFFICE VISITS | $30 copay |
| EMERGENCY ROOM | $200; Ambulance $100 copay |
| X-RAYS AND LAB TEST | $10 |
| INPATIENT HOSPITAL | $500 |
| OUTPATIENT SURGERY | $150 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.



# PHARMACY BENEFITS

## Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through BCBSTX and Kaiser. You may find information on our benefits coverage and search for network pharmacies by logging on to BCBSTX: **bcbstx.com**, **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.

| | BCBSTX Medical Plan | BASE PLAN w/ Difference Card | BUY UP PLAN w/ Difference Card |
|---|---|---|---|
| | NOT AN OPTION (For Reference) | IN-NETWORK | IN-NETWORK |
| **RETAIL RX (30-DAY SUPPLY)** | | | |
| GENERIC | 0%* | 20% / 20% / 20% / 20% after first $4,500 / $9,000 | 20% / 20% / 20% / 20% after first $6,000 / $12,000 |
| FORMULARY BRAND** | 0%* | | |
| NON-FORMULARY BRAND | 0%* | | |
| SPECIALTY DRUGS | 0%* | | |
| **MAIL ORDER RX (90-DAY SUPPLY)** | | | |
| GENERIC | 0%* | 20% / 20% / 20% / 20% after first $4,500 / $9,000 | 20% / 20% / 20% / 20% after first $6,000 / $12,000 |
| FORMULARY BRAND** | 0%* | | |
| NON-FORMULARY BRAND | 0%* | | |
| SPECIALTY DRUGS | 0%* | | |

**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 | $15 |
| FORMULARY BRAND | $35 |
| SPECIALTY | 30% ($250 maximum) |
| **MAIL ORDER RX (UP TO 100-DAY SUPPLY)** | |
| GENERIC | $30 |
| FORMULARY BRAND | $70 |

## 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**.

# 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.

| CONTRIBUTIONS | BCBSTX BASE PLAN | | BCBSTX BUY UP PLAN | |
|---|---|---|---|---|
| | BIWEEKLY | MONTHLY | BIWEEKLY | MONTHLY |
| EMPLOYEE ONLY | $42.76 | $92.65 | $101.96 | $220.91 |
| EMPLOYEE + SPOUSE | $281.99 | $610.98 | $374.61 | $811.65 |
| EMPLOYEE + CHILD(REN) | $246.54 | $534.18 | $334.26 | $724.23 |
| EMPLOYEE + FAMILY | $378.15 | $819.32 | $529.53 | $1,147.32 |

| CONTRIBUTIONS | KAISER HMO | |
|---|---|---|
| | BIWEEKLY | MONTHLY |
| EMPLOYEE ONLY | $76.50 | $165.75 |
| EMPLOYEE + SPOUSE | $363.37 | $787.31 |
| EMPLOYEE + CHILD(REN) | $330.69 | $716.50 |
| EMPLOYEE + FAMILY | $495.64 | $1,073.90 |

## 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 BCBSTX medical plan. For the PPO plans, you'll pay a copay.

For more information, please access your BCBSTX portal or call BCBSTX to help set up care at **800.521.2227**.

**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%.

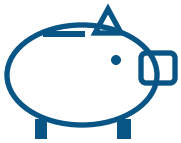
# OUT-OF-POCKET COSTS

**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**

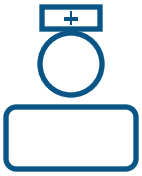




**Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes**

**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.

# 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**<br><br>You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit. | **Types of Care***<br><br>Answers to questions regarding:<br>• Symptoms<br>• Self-care / home treatments<br>• Medications and side effects | **Costs and Time Considerations****<br><br>• Usually available 24 hours a day, 7 days a week<br>• Typically, free as part of your medical insurance |
| **Telemedicine** | | |
| **When to Use**<br><br>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***<br><br>• Cold and flu symptoms<br>• Allergies<br>• Bronchitis<br>• Urinary tract infection<br>• Sinus problems | **Costs and Time Considerations****<br><br>• Usually, a first-time consultation fee and a flat fee or copay for any visit thereafter<br>• Usually immediate access to care<br>• Prescriptions through telemedicine or virtual visits not allowed in all states |
| **Primary Care Center** | | |
| **When to Use**<br><br>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***<br><br>• Routine checkups<br>• Immunizations<br>• Preventive services<br>• Manage your general health | **Costs and Time Considerations****<br><br>• Can require a copay and/or coinsurance<br>• Normally requires an appointment<br>• 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**<br>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**<br>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***<br>• Strains, sprains<br>• Minor broken bones (e.g., finger)<br>• Minor infections<br>• Minor burns<br>• X-rays | **Types of Care***<br>• Heavy bleeding<br>• Chest pain<br>• Major burns<br>• Spinal injuries<br>• Severe head injury<br>• Broken bones |
| **Costs and Time Considerations****<br>• Often requires a copay and/or coinsurance usually higher than an office visit<br>• Walk-in patients welcome, but waiting periods may be longer (urgency decides order) | **Costs and Time Considerations****<br>• Often requires a much higher copay and/or coinsurance<br>• Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first<br>• 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.*



# 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 2027.

| | CONTRIBUTIONS | |
|---|---|---|
| | BIWEEKLY | MONTHLY |
| EMPLOYEE ONLY | $13.15 | $28.49 |
| EMPLOYEE + SPOUSE | $27.73 | $60.09 |
| EMPLOYEE + CHILD(REN) | $33.13 | $71.78 |
| EMPLOYEE + FAMILY | $47.72 | $103.40 |

| | 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 2027.

| CONTRIBUTIONS | | |
|---|---|---|
| | Biweekly | Monthly |
| Employee Only | $4.32 | $9.37 |
| Employee + Spouse | $8.65 | $18.75 |
| Employee + Child(ren) | $9.09 | $19.69 |
| Employee + Family | $12.66 | $27.42 |

| | In-Network | Out-of-Network* | Frequency |
|---|---|---|---|
| **EXAMS** | | | |
| Copay | $10 | All amounts over $40 | Calendar year |
| **LENSES[1]** | | | |
| 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[4] | 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.

# TAX-ADVANTAGED BENEFITS

Flexible Spending Accounts

2027 BENEFITS GUIDE

# 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 $3,400 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.

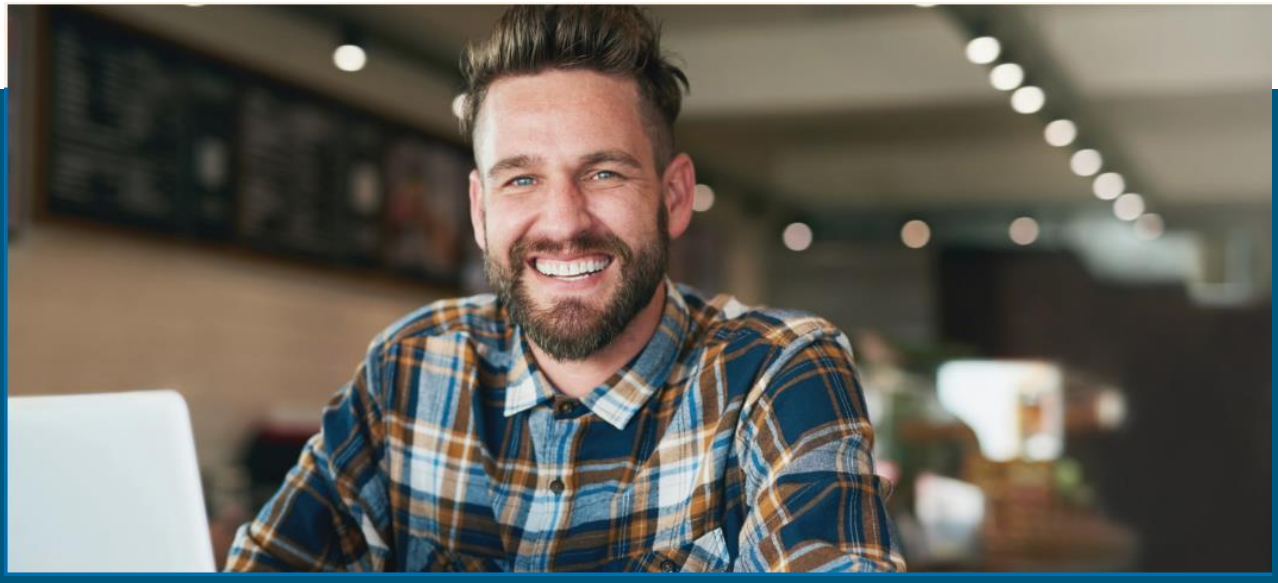
Submit a claim form along with the required documentation. Contact with reimbursement questions. If you need to submit a receipt, will notify you. Always save receipts for your records.

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 2027 plan year.
- Funds cannot be transferred between FSAs.
- You must “use it or lose it” — any unused funds will be forfeited.
- Up to $680 may be rolled over to the next plan year at the end of 2027 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

Accident, critical illness, and hospital indemnity

2027 BENEFITS GUIDE

# 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 UNUM, 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.

**Personal Safety Benefit:** Every year, each covered member who has Accident coverage can also receive $50 for completing a covered safety program. See schedule of benefits for more information.

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

| 2027 ACCIDENT RATES | | |
|---|---|---|
| | Employee Biweekly | Employee Monthly |
| Employee Only | $3.64 | $7.88 |
| Employee + Spouse | $7.28 | $15.77 |
| Employee + Child(ren) | $8.59 | $18.61 |
| Employee + Family | $12.23 | $26.50 |

## Critical Illness Coverage

Critical Illness coverage through UNUM 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 Disease Major (50%) / Minor (10%)
- Complete Blindness
- Invasive Cancer
- Addison's Disease
- Non-Invasive Cancer (25%)
- Infectious Disease
- Skin Cancer ($500)
- Multiple Sclerosis
- Lupus
- Huntington's Disease
- Parkinson's Disease
- Permanent Paralysis
- End Stage Kidney 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) are automatically covered with employee
- **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.

| ATTAINED AGE | 2027 MONTHLY CRITICAL ILLNESS RATES | | | |
|---|---|---|---|---|
| | $10,000 BENEFIT | | $20,000 BENEFIT | |
| | EMPLOYEE & CHILD(REN) | SPOUSE | EMPLOYEE & CHID(REN) | SPOUSE |
| <25 | $3.90 | $3.90 | $7.80 | $7.80 |
| 25–29 | $4.10 | $4.20 | $8.20 | $8.40 |
| 30–34 | $5.00 | $5.20 | $10.00 | $10.40 |
| 35–39 | $6.30 | $6.50 | $12.60 | $13.00 |
| 40–44 | $8.50 | $8.80 | $17.00 | $17.60 |
| 45–49 | $12.00 | $12.10 | $24.00 | $24.20 |
| 50–54 | $16.90 | $16.00 | $33.80 | $32.00 |
| 55–59 | $23.90 | $21.40 | $47.80 | $42.80 |
| 60–64 | $33.90 | $29.40 | $67.80 | $58.80 |
| 65–69 | $50.20 | $40.30 | $100.40 | $80.60 |
| 70-74 | $67.10 | $54.90 | $134.20 | $109.80 |
| 75+ | $88.50 | $77.10 | $177.00 | $154.20 |

**IMPORTANT: This is a fixed indemnity policy,**

**NOT health insurance**

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

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

**Looking for comprehensive health insurance?**

- Visit **HealthCare.gov** or call **800.318.2596** (TTY: 855.889.4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

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

## 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. UNUM will send a check directly to you — not to your medical providers — upon approval of your claim. You decide how you spend the money. ***IMPORTANT: TEAM, Inc. offers a fixed indemnity policy; this is NOT health insurance. If you are considering purchasing this policy, please read the notice above in its entirety.***

**Key Advantages**

- Pays you 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

| 2027 HOSPITAL INDEMNITY RATES | | |
|---|---|---|
| | EMPLOYEE BIWEEKLY | EMPLOYEE MONTHLY |
| EMPLOYEE ONLY | $7.45 | $16.15 |
| EMPLOYEE + SPOUSE | $14.65 | $31.75 |
| EMPLOYEE + CHILD(REN) | $8.71 | $18.88 |
| EMPLOYEE + FAMILY | $15.91 | $34.48 |

# FINANCIAL PROTECTION

Life, disability, and retirement benefits

2027 BENEFITS GUIDE



# 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 UNUM, 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 UNUM insurance.

Name a primary and contingent beneficiary to make your intentions clear. 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 | 4x 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 for newly eligible employees and dependents up to the guaranteed issue amount |
| **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 | Birth–6 months: $1,000 / 6 months–age 26: $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: $6,000–$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.

| AGE (AS OF JANUARY 1, 2027) | VOLUNTARY LIFE INSURANCE | | |
|---|---|---|---|
| | RATES/$1,000 (MONTHLY) | | |
| | EMPLOYEE | AGE (AS OF JANUARY 1, 2027) | SPOUSE |
| <25 | $0.060 | <25 | $0.036 |
| 25-29 | $0.060 | 25-29 | $0.036 |
| 30-34 | $0.080 | 30-34 | $0.045 |
| 35-39 | $0.090 | 35-39 | $0.063 |
| 40-44 | $0.140 | 40-44 | $0.081 |
| 45-49 | $0.210 | 45-49 | $0.117 |
| 50-54 | $0.370 | 50-54 | $0.180 |
| 55-59 | $0.670 | 55-59 | $0.270 |
| 60-64 | $0.860 | 60-64 | $0.459 |
| 65-69 | $1.330 | 65-69 | $0.774 |
| 70 and older | $2.060 | 70 and older | $1.323 |

**Note**: Rate changes when moving to a new age band will occur on January 1, the start of the plan year. The spouse rate is based on employee age.

| VOLUNTARY CHILD LIFE INSURANCE |
|---|
| MONTHLY COST PER $10,000 |
| $0.090 |

| 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.

## 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<br>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<br>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.

## Basic Long-Term Disability (LTD) 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** | |
| MONTHLY MAXIMUM BENEFIT | $5,000 |
| ELIMINATION PERIOD | 180 Days |
| **Salary Employees** | |
| MONTHLY 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 UNUM at **866.868.6737** to report your disability or other absence claims including leaves that qualify as Family and Medical Leave (FMLA).

FMLA provides up to 12 weeks of unpaid, job-protected leave in any 12-month period for certain qualifying 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 UNUM at **866.868.6737** or submit online at **https://portal.unum.com**.

# 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 regular full-time or part-time 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.<br><br>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, consider how much you contributed at your previous employer and adjust your contributions accordingly so not to exceed the IRS 402(g) limits.

**After-tax Contributions**
You pay taxes on these contributions today. You can withdraw contributions tax-free, but you pay taxes on any earnings on these contributions.

**Roth-In-Plan Conversions**
You can convert pre-tax and after-tax money to Roth and pay taxes on the taxable portion today. You can withdraw converted money, including any earnings generated after the conversion, tax-free once certain conditions are met.



## 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 employer match and 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**)

# PERSONAL BENEFITS

Additional programs and support

2027 BENEFITS GUIDE

# PERSONAL 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 **1.800.854.1446** or online at **unum.com/lifebalance**.

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 Assist America as part of your Long-Term Disability Insurance benefits with Unum.

Assist America offers you and your family access to emergency services while you travel, plus the advantage of concierge assistance for personal and work-related travel and entertainment requests. This service provides you and your dependents with medical, legal, transportation and financial assistance 24/7/365 when you are more than 100 miles away from home.

Please visit the travel website for more information at **www.AssistAmerica.com**. For help, call **800.872.1414**. If you are outside the U.S., call **+609.986.1234** and use Reference Number 01-AA-UN-762490.

## Legal Coverage

You can purchase affordable Legal coverage through MetLife 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.

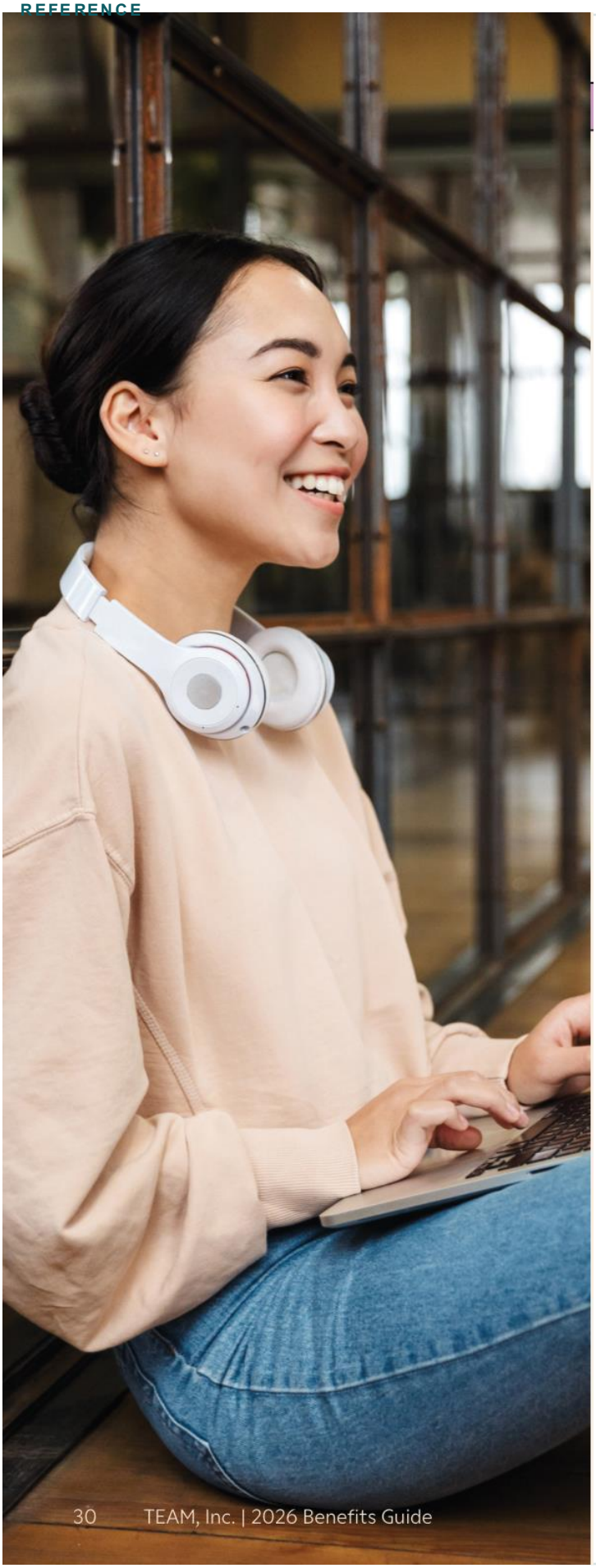
## Benefit Advocate Center

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**.



# REFERENCE

Glossary, required notices, and contacts




# 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 TEAM, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, TEAM, Inc. 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 **bcbstx.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 **bcbstx.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, 2027, 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, 2026. 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://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.mycohibi.com/
HIBI Customer Service: 855.692.6442

**FLORIDA – Medicaid**
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

**GEORGIA – Medicaid**
GA HIPP: https://medicaid.georgia.gov/
health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/
childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

**INDIANA – Medicaid**
Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584
Family and Social Services Administration
http://www.in.gov/fssa/dfr/ | 800.403.0864

**IOWA – Medicaid and CHIP (Hawki)**
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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://kynect.ky.gov | 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/health-care-coverage/
800.657.3672

**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. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

**NEW JERSEY – Medicaid and CHIP**
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
800.356.1561
CHIP: http://www.njfamilycare.org/index.html
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

**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 and CHIP**
http://healthcare.oregon.gov/Pages/index.aspx
800.699.9075

**PENNSYLVANIA – Medicaid and CHIP**
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
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**
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
800.440.0493

**UTAH – Medicaid and CHIP**
Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

**VERMONT – Medicaid**
https://dvha.vermont.gov/members/medicaid/hipp-program
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 and CHIP**
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, 2026, 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 1/31/2027)

## 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

## 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)**

## 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, 2026 |
| **Name of Entity/Sender:** | TEAM, Inc. |
| **Contact:** | Human Resources |
| **Address:** | 13131 Dairy Ashford Road, Suite 600<br>Sugar Land, TX 77478 |
| **Phone Number:** | 281.388.4090 (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 period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

**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)**

# Marketplace Notice

**Health Insurance Marketplace Coverage Options and Your Health Coverage**

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

### Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

### When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

### What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

### How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources at 281.388.4090, Option 1.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | |
|---|---|---|
| 3. Employer name | 4. Employer Identification Number (EIN) | |
| 5. Employer address | 6. Employer phone number | |
| 7. City | 8. State | 9. ZIP code |
| 10. Who can we contact about employee health coverage at this job? | | |
| 11. Phone number (if different from above) | 12. Email address | |

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

- As your employer, we offer a health plan to:

  ✓ All employees. Eligible employees are full-time employees working at least 30 hours per week.

- With respect to dependents:
  ✓ We do offer coverage. Eligible dependents are spouses and dependent children under the age of 26.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

# IMPORTANT CONTACTS

## Medical

**BCBSTX**
800.521.2227
bcbstx.com

**Kaiser**
800.464.4000
kp.org

## Difference Card

888.343.2110
differencecard.com
Smart phone App

## Dental

**BCBSTX**
800.521.2227
bcbstx.com

## Vision

**BCBSTX (EyeMed)**
855.556.8796
eyemedvisioncare.com/bcbstxvis

## Perks at Work

**perksatwork.com**

## Healthcare Flexible Spending Accounts

**HSA Bank**
844.650.8936
hsabank.com

## Life and AD&D

**UNUM**
800.445.0402
unum.com/employees/Benefits

## Disability

**UNUM**
866.868.6737
unum.com/employees/Benefits

## Supplemental Health (Accident, Critical Illness, Hospital Indemnity)

**UNUM**
866.635.5597
unum.com/employees/Benefits

## Employee Assistance Program

**HealthAdvocate**
1.800.854.1446
unum.com/lifebalance

## Retirement

**Fidelity**
800.835.5097
netbenefits.com

## Prepaid Legal Coverage

**MetLife Legal Plans**
legalplans.com

## Travel Assistance

**Assist America**
Reference Number: 01-AA-UN-762490
Within the U.S. or Canada:
1.800.872.1414
Outside U.S. or Canada:
+1 609.986.1234

## 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 document is an outline of the coverage provided under your employer's benefit plans. Refer to the official plan documents for complete terms, coverage, exclusions, limitations, and conditions.

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