2026

EMPLOYEE BENEFITS GUIDE

for a healthy you

aspire hr
employees first

We are pleased

to offer a full benefits package to you and your eligible dependents. Read this guide to know what benefits are available to you. You may only enroll for or make changes to your benefits during Open Enrollment or when you have a Qualifying Life Event.

Availability Of Summary Health Information

Your plan offers medical coverage. To help you make an informed choice, review each plan's Summary of Benefits and Coverage (SBC) available from Human Resources.

YOUR NEW BENEFITS BEGIN

January 1, 2026

AND CONTINUE THROUGH

December 31, 2026

Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 29 for more details.

Important Contacts

Program	Provider	Group No.	Phone	Website/Email
Medical	BlueCross BlueShield of TX	307084	800-521-2227	www.bcbstx.com
Telemedicine	MD Live through BCBS	307084	888-680-8646	www.mdlive.com/bcbstx
Dental	Guardian	00581680	888-482-7342	www.guardiananytime.com
Vision	Guardian	00581680	888-482-7342	www.guardiananytime.com
Health Savings Account	HSA Bank	N/A	800-357-6246	www.hsabank.com
Flexible Spending Accounts	Flores	N/A	855-647-6762	www.flores247.com
Life and AD&D	Guardian	00581680	888-482-7342	www.guardiananytime.com
Disability	Guardian	00581680	888-482-7342	www.guardiananytime.com
Accident	Guardian	00581680	888-482-7342	www.guardiananytime.com
Critical Illness	Guardian	00581680	888-482-7342	www.guardiananytime.com
Hospital Indemnity	Guardian	00581680	888-482-7342	www.guardiananytime.com
Employee Assistance Program	Guardian	00581680	800-386-7065	www.worklife.uprisehealth.com Access Code: worklife
Will Prep	Guardian	00581680	888-482-7342	www.guardiananytime.com
401(k)	Ascensus	280608	866-809-8146	https://myaccount.ascensus.com/GoldmanSachs
Human Resources	Jessica Ragsdill		972-372-2820	jragsdill@aspirehr.com
Benefits Specialist	Endeavor Risk Advisors Lisa Burkham, Sr. Acct Mgr.		972-559-0461	clientservice@endeavorrisk.com lisa@endeavorrisk.com

Eligibility

new hire

who is eligible

- A regular, full-time employee working an average of 30 hours per week

when to enroll

- Enroll within 31 days of your start date

when coverage starts

- First of the month after date of hire

employee

who is eligible

- A regular, full-time employee working an average of 30 hours per week

when to enroll

- Enroll during annual open enrollment (OE) or when you have a qualifying life event (QLE). Changes due to a QLE must be made within 31 days of the event

when coverage starts

- OE: Start of the plan year
- QLE: Ask Human Resources

dependent(s)

who is eligible

- Your legal spouse or domestic partner
- Child(ren) under age 26, regardless of student, dependency or marital status
- Child(ren) over age 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

when to enroll

- You must enroll the dependent(s) during your annual open enrollment (OE) or when you or they have a qualifying life event (QLE). Changes due to a QLE must be made within 31 days of the event
- When covering dependents, you must enroll for and be on the same plans

when coverage starts

- Based on 2026 effective dates

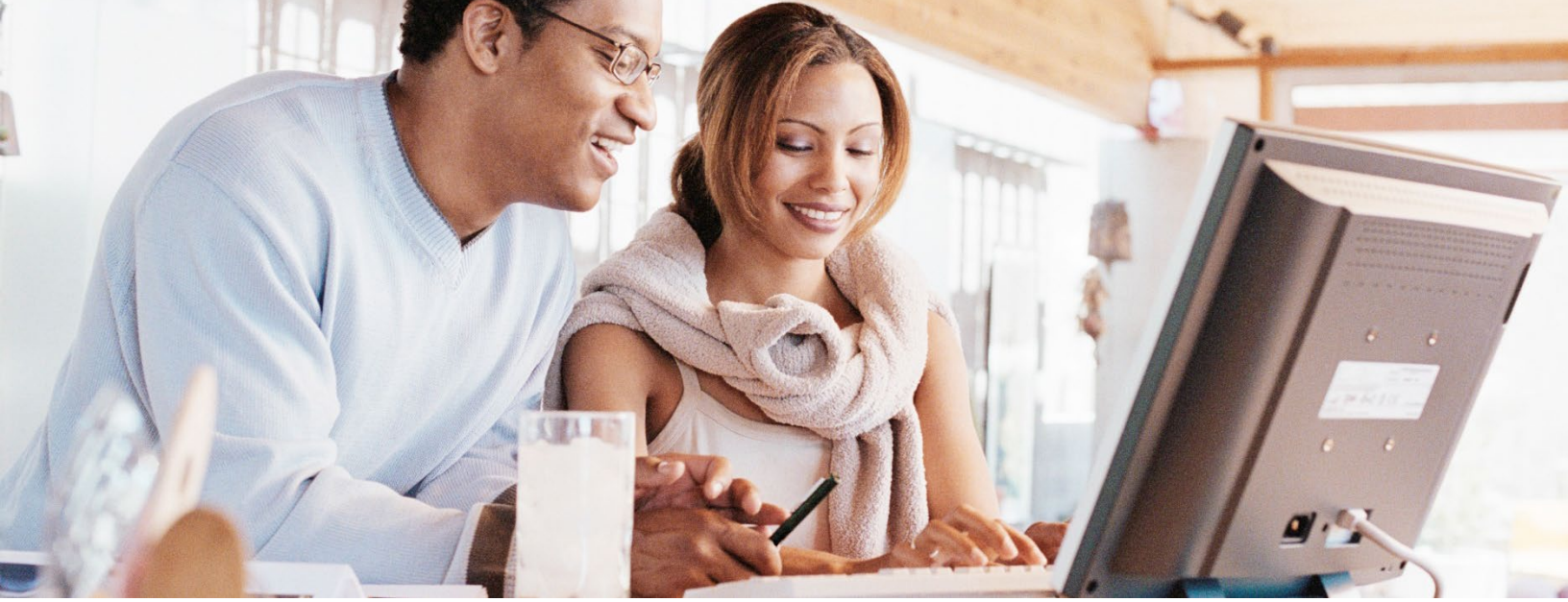
Qualifying Life Events

CHANGING COVERAGE OUTSIDE OF OPEN ENROLLMENT

You may only change coverage during the plan year if you have a Qualifying Life Event, such as:

Marriage	Birth	FMLA, COBRA event, court judgement or decree
Divorce	Adoption/placement for adoption	Becoming eligible for Medicare, Medicaid, or TRICARE
Legal separation	Change in benefits eligibility	Receiving a Qualified Medical Child Support Order
Annulment	Gain or loss of benefits coverage	
Death	Change in employment status affecting benefits	

You have 31 days from the event to notify HR and complete your changes.
You may need to provide documents to verify the change.



How to Enroll Online

To begin the enrollment process, go to
www.employeenavigator.com

First time users: Follow steps 1-4

Returning users: Log in and start at step 5.

1	**All users** https://www.employeenavigator.com/benefits/Account/Register Everyone must register by accessing the registration link above.
2	Enter your personal information and Company Identifier of **AspireHR2025** and click ***Next***.
3	Create a username (work email address recommended) and password, then check the ***I agree to terms and conditions*** box before you click ***Finish***.
4	If you used an email address as your username, you will receive a validation email to that address. You may now log in to the system.
5	Confirm or update your personal information and click ***Save & Continue***.
6	Edit or add dependents who need to be covered on your benefits. Once all dependents are listed, click ***Save & Continue***.
7	Follow the steps on the screen for each benefit to select or decline coverage. To decline coverage, click ***Don't want this benefit?*** and select the reason for declining.
8	When you finish making your benefit elections, review your selections. If correct, click the ***Click to Sign*** button to complete and submit your enrollment choices.

Employee Help Desk

You have questions – please reach out to our benefits advisor, Endeavor Risk Advisors

972-220-0895

Questions can also be emailed to:

clientservice@endeavorrisk.com

Medical Coverage

The medical plan options through **BlueCross BlueShield of Texas** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of 4 plans:

- BlueChoice HSA – Blue
- BlueChoice HSA – Platinum
- BlueChoice PPO – Blue
- BlueChoice PPO - Platinum

Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see in-network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use non-network providers. When you see in-network providers, your office visits, urgent care, and prescription drugs are covered with a copay and most other network services are covered at the deductible and coinsurance level.

High-Deductible Health Plan (HDHP)

The HDHP allows you to see any provider when you need care, but you will pay less for care when you go to network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescriptions. If you enroll in the HDHP, you may be eligible to open a Health Savings Account .

Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Out-of-Pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance. *Except for Grandfathered medical plans

Copays and Coinsurance

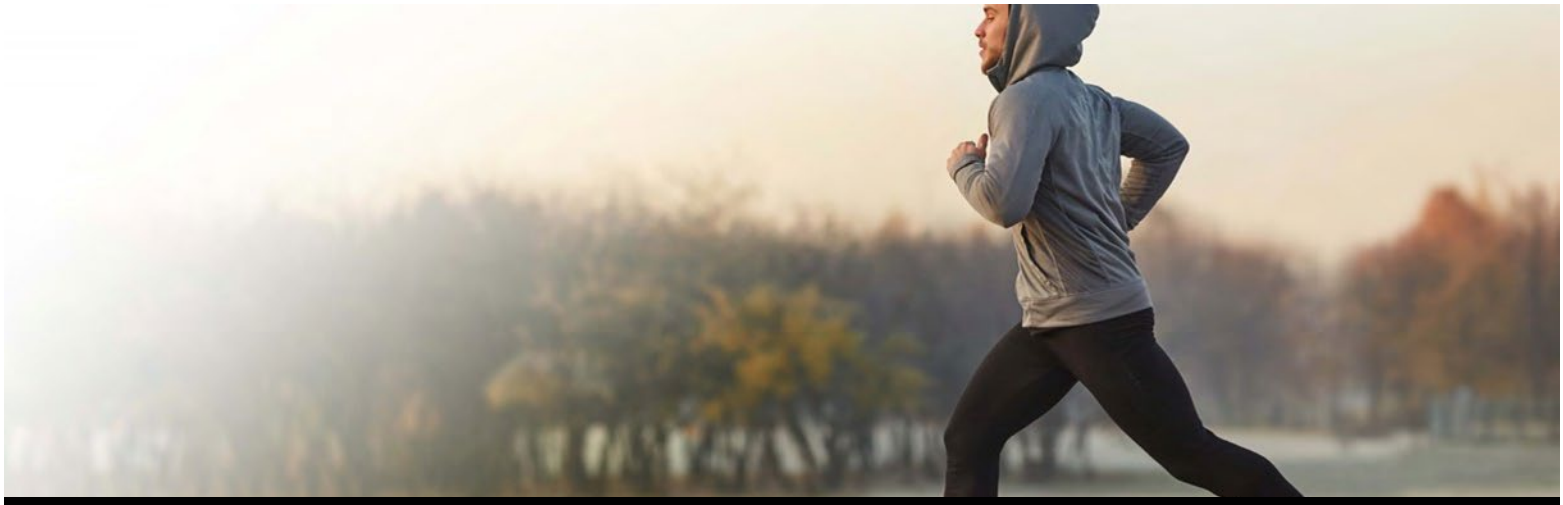
These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount, and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

Plan Types

- EPO/PPO – A network of doctors, hospitals and other health care providers
- HMO - A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care.
- POS - Combines aspects of a PPO and HMO
- HDHP - A plan that has higher annual deductibles in exchange for lower premiums

Find a Provider

- Call **800-521-2227**
- Visit **www.bcbstx.com**
- Download the mobile app



Preventative Care

Wellness and Health Management

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include ge. ng regular physical examinations, mammograms and immunizations. Through the plans offered by Blackburn Transportation Group, all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

Which preventative care services are covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers.

Below is a list of common services that are included in the plans offered this year:

- Routine colorectal cancer screening
- Routine prostate test
- Routine lab procedures
- Routine mammograms
- Routine pap smear
- Smoking cessation
- Health education/counseling services
- Health counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and counseling for domestic violence
- Routine physical exam
- Well baby and child care
- Well women visits Immunizations
- Routine bone density test
- Routine breast exam
- Routine gynecological exam
- Screening for Gestational diabetes
- Obesity screening and counseling
- Routine digital rectal exam
- Routine colonoscopy

Medical Plan Comparison – HDHP HSA Plans

	BlueChoice HSA – Blue		BlueChoice HSA – Platinum	
Provider Network	BlueChoice		BlueChoice	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible • Individual • Family	$5,000 $10,000	$10,000 $12,000	$3,500 $7,000	$7,000 $14,000
Out-of-Pocket Maximum • Individual • Family	$6,900 $13,800	Unlimited Unlimited	$5,000 $10,000	Unlimited Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
General Level of Coverage	80%	60%	80%	60%
	You Pay		**You Pay**	
Preventive Care	$0	40%[1]	$0	40%[1]
Primary Care Physician	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Specialist	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Diagnostic Lab and X-ray	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Complex Imaging	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Urgent Care	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Emergency Room	20% after Ded.		20% after Ded.	
Inpatient Hospital Services	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Outpatient Services	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Prescription Drugs – Retail Up to 30-day supply • Generic • Preferred brand name • Non-preferred brand name • Specialty	 10% / 20% 20% / 20% 30% / 40% 40% / 50%	 40%[1] 40%[1] 40%[1] 40%[1]	 10% / 20% 20% / 20% 30% / 40% 40% / 50%	 40%[1] 40%[1] 40%[1] 40%[1]
Prescription Drugs – Mail Order Up to 90-day supply • Generic • Preferred brand name • Non-preferred brand name	 20% 40% 50%	 40%[1] 40%[1] 40%[1]	 20% 40% 50%	 40%[1] 40%[1] 40%[1]
Employee Per Paycheck Contributions				
Employee	$68.21		$103.88	
Employee + Spouse	$289.01		$363.14	
Employee + Child(ren)	$241.85		$347.89	
Employee + Family	$421.32		$513.36	

[1] What you pay after your deductible is met.

[2] In-network preferred pharmacy copay versus in-network non-preferred pharmacy copay.

Medical Plan Comparison – PPO Copay Plans

	BlueChoice PPO – Blue		BlueChoice PPO - Platinum	
Provider Network	BlueChoice		BlueChoice	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible • Individual • Family	$3,000 $9,000	$10,000 $20,000	$1,500 $4,500	$3,000 $9,000
Out-of-Pocket Maximum • Individual • Family	$9,000 $18,000	Unlimited Unlimited	$6,000 $18,000	Unlimited Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
General Level of Coverage	80%	60%	80%	60%
	You Pay		**You Pay**	
Preventive Care	$0	40%[1]	$0	40%[1]
Primary Care Physician	$40 copay	40%[1]	$40 copay	40%[1]
Specialist	$80 copay	40%[1]	$80 copay	40%[1]
Diagnostic Lab and X-ray	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Complex Imaging	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Urgent Care	$75 copay	40%[1]	$75 copay	40%[1]
Emergency Room	$500 plus 20%[1]		$500 plus 20%[1]	
Inpatient Hospital Services	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Outpatient Services	20% after Ded.	40%[1]	20% after Ded.	40%[1]
Prescription Drugs – Retail Up to 30-day supply • Generic • Preferred brand name • Non-preferred brand name • Specialty	$0 / $10 / 20 $50 / $70 $100 / $120 $150 / $250	40%[1] 40%[1] 40%[1] 40%[1]	$0 / $10 / 20 $50 / $70 $100 / $120 $150 / $250	40%[1] 40%[1] 40%[1] 40%[1]
Prescription Drugs – Mail Order Up to 90-day supply • Generic • Preferred brand name • Non-preferred brand name	$30 $150 $300	40%[1] 40%[1] 40%[1]	$30 $150 $300	40%[1] 40%[1] 40%[1]
Employee Per Paycheck Contributions				
Employee	$232.42		$263.90	
Employee + Spouse	$492.41		$652.27	
Employee + Child(ren)	$359.74		$594.11	
Employee + Family	$717.87		$970.32	

[1] What you pay after your deductible is met.

[2] In-network preferred pharmacy copay versus in-network non-preferred pharmacy copay.

BCBSTX Resources

Blue Access for Members

Blue Access for Members (BAM) is the secure BCBSTX member website where you can:

- Check claim status or history
- Confirm dependent eligibility
- Sign up for electronic Explanation of Benefits
- Locate in-network providers
- Print or request an ID card
- Review your benefits
- Get tips to live and eat healthier

To get started, log on to **www.bcbstx.com** and use the information on your BCBSTX ID card to complete the registration process.

Mobile App

The BCBSTX mobile app can help you stay organized and in control of your health anytime, anywhere. Log in from your mobile device to access your BAM account, including:

- Track account balances and deductibles
- Access ID card information
- Find doctors, dentists, and pharmacies

Nurseline

Call **800-581-0368** for immediate access to registered nurses who can answer general health questions, make appointments with your doctor and help determine where to go for immediate or emergency health care services. You can also access an audio library of more than 1,000 health-related topics in both English and Spanish.

Member Rewards

Sometimes it is hard to maintain a healthy lifestyle, and you may need a little motivation. The **Blue Points** program serves as motivation to help you get on track – and stay on track – to reach your wellness goals. Access **www.wellontarget.com** to find all the interactive tools and resources you need to start racking up Blue Points. Keep yourself motivated to earn more points by viewing the online shopping mall and checking out all the rewards you can earn for adopting – and continuing – healthy habits.

Blue 365

Blue365 can help you save money on health and wellness products and services not covered by insurance. There are no claims to file, and you do not need a referral or preauthorization. Sign up for Blue365 at **www.blue365deals.com/bcbstx** to receive weekly Featured Deals by email. Discount categories include:

- Apparel and footwear
- Fitness
- Hearing and vision
- Home and family
- Nutrition
- Personal care

Chronic Medical Care

Hinge Health

If you suffer from constant back and joint pain, **Hinge Health** can help without drugs or surgery. Get personal therapy, unlimited support, a computer tablet, and wearable sensors — all for free! Average results show 60% pain reduction and two out of three surgeries avoided. Your remote care may be done in the comfort of your own home. You will begin with a 12-week intensive phase, followed by an ongoing program that builds on what you have learned. Learn more and apply at **www.hingehealth.com/bcbstx**.

Omada

If you are at risk of diabetes and/or high blood pressure, **Omada** helps you change the habits that put you most at risk for developing a chronic condition. A virtual care team will work with you to create a program to reduce your risk and build healthy habits. You will receive weekly support and connect with a small group of peers, all from the comfort of your own home. If you have any health claims that show you may be at risk for diabetes or high blood pressure, Omada will reach out to you directly. Visit **www.omadahealth.com/bcbstx** for more information.

Wondr

If you would like to lose weight and change how your body stores and uses energy, **Wondr** may be right for you. Wondr is a 100% digital weight loss program that teaches you how to eat your favorite foods and still lose weight, have energy, stress less, and sleep better. Wondr is not a diet plan. There are no points, plans, or calories to count. It teaches you skills to know how and when you eat and improve your long-term health. Learn more and enroll at **https://wondrhealth.com/bcbstx**.

Livongo

Livongo offers digital solution programs to help you manage chronic diabetes and high blood pressure (hypertension). Participation is **FREE** and available to you and your family members.

Diabetes Management Program

Manage Type 1 and Type 2 diabetes by using:

- **Livongo's advanced blood glucose meter** – Get immediate feedback and alert loved ones in real time (using a cellular connection) when your blood glucose is too high or low
- **Unlimited strips and lancets** – Livongo ships supplies directly to you at NO COST
- **Real-time tips and support** – Get 24/7 support if your glucose is not in range or if you want tips on diabetes management

High Blood Pressure Management Program

Livongo offers personal support by monitoring your blood pressure using:

- A wireless, connected blood pressure cuff
- Support and coaching with licensed professionals 24/7
- Notifications and reminders for high blood pressure readings
- Blood pressure reading reports

Participation in Livongo is Easy!

- **800-945-4355**
- **https://get.livongo.com/txhealth/register**
- Text **GO TXHEALTH** to **85240** to download the app to your smartphone or mobile device

Use registration code TXHEALTH when prompted.

Virtual Care

Your medical coverage offers virtual care services through

BCBS of Texas – MDLIVE® Virtual Visits

24/7 Access to Board-Certified Doctors — Anytime, Anywhere

What is MDLIVE?

MDLIVE® allows Blue Cross and Blue Shield of Texas (BCBSTX) members to speak with a doctor or behavioral health professional by video, phone, or mobile app — day or night, 365 days a year. No waiting rooms. No appointments needed. No extra cost surprises.

Why Use MDLIVE?

- **Convenient — See a doctor from home, work, or on the go**
- **Fast — Most visits start within minutes**
- **Reliable — Experienced, board-certified physicians**
- **Affordable — Low copay for most plans**
- **Secure — Private and HIPAA-compliant**

How to Get Started

- **Download the MDLIVE® App - App Store or Google Play**
- **Create Your Account - Use the information on your BCBSTX member ID card**
- **Choose Your Visit Type - Medical / Behavioral Health**
- **Start Your Virtual Visit**

When to Use Virtual Care

Use virtual care / telehealth services for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold/Flu
- Mental health issues
- Allergies
- Fever
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

Need Help?
MDLIVE Support: 1-888-LIVE-MD1
BCBSTX Customer Service: (number on your member ID card)

Virtual Visits: **Get Cost-Effective, 24/7 Care**

With Virtual Visits from MDLIVE®, the doctor is always in. This Blue Cross and Blue Shield of Texas (BCBSTX) benefit gives you access to 24/7 non-emergency care from a board-certified doctor or therapist by phone, online video or mobile app from almost anywhere.

Skip expensive ER bills and waiting to see a doctor. You can speak with a Virtual Visits doctor within minutes.

Services are available in both English and Spanish with translation services available in other languages.

Powered by MDLIVE

Health Care Options

Becoming familiar with your options for medical care can save you time and money.

Non-Emergency Care			
Telehealth **Access to care via phone, online video or mobile app** whether you are home, work or traveling; medications can be prescribed. 24 hours a day, 7 days a week	Allergies Cough/cold/flu Rash Stomachache	**$**	**2-5 minutes**
Doctor's Office Generally, the **best place for routine preventive care**; established relationship; able to treat based on medical history. Office hours vary	Infections Sore and strep throat Vaccinations Minor injuries/sprains/strains	**$**	**15-20 minutes**
Retail Clinic Usually **lower out-of-pocket cost** than urgent care; when you can't see your doctor; located in stores and pharmacies. Hours vary based on store hours.	Common infections Minor injuries Pregnancy tests Vaccinations	**$**	**15 minutes**
Urgent Care When you need **immediate attention**; walk-in basis is usually accepted. Generally includes evening, weekend and holiday hours	Sprains and strains Minor broken bones Small cuts that may require stitches Minor burns and infections	**$$**	**15-30 minutes**
Emergency Care			
Hospital ER **Life-threatening or critical conditions; trauma treatment**; multiple bills for doctor and facility. 24 hours a day, 7 days a week	Chest pain Difficulty breathing Severe bleeding Blurred or sudden loss of vision Major broken bones	**$$$$**	**4+ hours**
Freestanding ER Services do not include trauma care; can look similar to an urgent care center, but **medical bills may be 10 times higher**. 24 hours a day, 7 days a week	Most major injuries except trauma Severe pain	**$$$$$**	**varies**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account

A Health Savings Account (HSA) is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no “use it or lose it” rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse’s health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else’s tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Important HSA Information

- Always ask your network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA with our administrator, HSA Bank. Please visit HSA Bank at www.hsabank.com to get started.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The 2026 annual contribution maximum is based on the coverage option you elect:

- Individual – $4,400
- Family (filing jointly) – $8,750

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Aspire HR **matches** your contributions up to **$1,000** per plan year. Please note, these funds count towards your annual maximum contribution.

Opening an HSA

If you meet the eligibility requirements, you may open an HSA administered by **HSA Bank**. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA. To open an account, go to **www.hsabank.com**.

Flexible Spending Accounts

This is how an FSA works:

- You set aside money for your FSA from your paycheck before taxes are taken out.
- You then use your pre-tax FSA funds throughout the plan year to pay for eligible health care or dependent care expenses.
- You save money on expenses you're already paying for.

You may also be able to carry over up to $680 of unused funds to the following year. Refer to your FSA documentation for more details.

Health FSA Eligible Expenses

Max contribution for 2026 - $3,400

- Medical expenses: copays, coinsurance and deductibles
- Dental expenses: exams, cleanings, X-rays and braces
- Vision expenses: exams, contact lenses, eyeglasses and laser eye surgery
- Professional services: physical therapy, chiropractic and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items such as bandages, pregnancy test kits and blood pressure monitors

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you enrolled in the HDHP medical plan and contribute to an HSA. You can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only.

Dependent Care FSA

- Care for your child who is under the age of 13 Before- and after-school care
- Babysitting and nanny expenses
- Day care, nursery school and preschool Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

Important FSA Rules

- The maximum per plan year you can contribute to a Health Care or Limited Purpose FSA is $3,400. The maximum per plan year you can contribute to a Dependent Care FSA is $7,500 when filing jointly or head of household and $3,750 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- You can continue to file claims incurred during the plan year through **March 15th, 2026**.
- Your Health Care or Limited Purpose FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- The IRS has amended the “use it or lose it rule” to allow you to carry-over up to $680 in your Health Care FSA into the next plan year. The carryover rule does not apply to your Dependent Care FSA.

Flores is the new administrator as of January 1, 2026.
Any rollover funds will be sent to Flores on your behalf.

Wellness Program

Prioritize Your Health and Well-Being

At Aspire HR, we believe that a healthy workforce is a happy and productive workforce. That's why we're excited to offer a comprehensive Wellness Program designed to support your physical, mental, and emotional well-being. With a variety of ways to participate, you can take charge of your health while also earning incentives.

How to Participate and Earn Incentives

There are three easy ways to participate in the Wellness Program and start earning rewards:

1. Annual Wellness Visit with Your Primary Care Physician (PCP)

Schedule and complete your Annual Wellness Visit with your PCP. Have your doctor complete the attestation form and submit it to HR to **save $10 per pay period** on your medical plan contributions.

- **Savings are effective the pay period following your visit and last for 12 months.**
- **Eligibility:** This option is available to employees enrolled in Aspire HR medical plans.

2. Attend Webinars and Complete Wellness Activities

Attend at least three (3) wellness webinars or complete wellness activities through our vendor partners (e.g., BCBS, Guardian, Ascensus).

- Submit proof of your participation to HR to earn an additional incentive.
- **Eligibility:** This option is available to employees enrolled in Aspire HR medical plans.

3. Engage in Additional Wellness Program Initiatives

Throughout the year, there will be various wellness initiatives and events. Participation may vary, but there will be additional incentives offered for your involvement.

- **Eligibility:** Open to all employees, regardless of medical plan enrollment.

Important Details:

•To qualify for savings on medical contributions through Options 1 and 2, employees **must be enrolled in an Aspire HR medical plan.**

•Option 3 is open to **all employees**, whether or not you are enrolled in the medical plan.

Why Participate?

Your health and well-being are important to us. By participating in the Wellness Program, not only can you improve your overall health, but you can also enjoy financial savings and additional incentives along the way. Take advantage of these opportunities and make wellness a priority in your life.

.

Find a Provider

- Call **800-541-7846**
- Visit **www.guardiananytime.com**
- Download the mobile app

Dental Coverage

Summary of coverage

Dental coverage is similar to regular medical insurance—you pay a premium and then your insurance will cover part or all of the cost for many dental services.

Preventative care

Professional dental care can diagnose or help prevent common dental problems, including toothaches, inflamed gums, tooth decay, bad breath and dry mouth. If conditions like these remain untreated, they can worsen into painful and expensive problems, such as gum disease or even tooth loss.

Great for families

This coverage is also great for families. Since dental work can be very expensive, proactive dental care, such as routine cleanings, can help save children from costly issues as they age.

Routine care

Dental coverage allows you to visit a dentist whenever you need to inexpensively receive preventative and diagnostic care.

Diagnostic care

Additionally, dental health professionals are able to spot more serious health issues, including some types of cancer. That makes it even more important to see a dentist regularly.

Specialized treatments

With dental insurance, you're investing in your smile and overall health. Beyond cleanings and routine care, dental coverage may also help pay for more specialized treatments, such as root canals or fillings.

See everything your plan covers by reviewing the benefits statement and overview. Reach out to HR with any questions.

Find a Provider

- Call 800-541-7846
- Visit www.guardiananytime.com
- Download the mobile app

Dental Coverage

Summary of coverage

There are both in and out of network benefits. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in network providers. Out of network providers may balance bill you.

	Blue Plan	Platinum Plan
	In-Network[1]	In-Network[1]
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150
Calendar Year Benefit Maximum Per Individual	$1,000	$2,500
	You Pay	**You Pay**
Preventive Care Oral Exams 2 times a year, Cleanings 2 times a year, X-rays	$0	$0
Basic Restorative Care Fillings, Extractions, Root Canal	50% after deductible	20% after deductible
Major Restorative Crowns, Bridge work, Dentures	Not Covered	50% after deductible
Orthodontia (dependent children under 19)	Not Covered	50%
Orthodontia Lifetime Maximum	Not Covered	$1,000
Employee Per Paycheck Contributions		
Employee	$0.00	$10.49
Employee + Spouse	$7.28	$29.49
Employee + Child(ren)	$12.67	$36.04
Employee + Family	$21.63	$52.31

[1] See your plan for details about out-of-network coverage.

Vision Coverage

Summary of coverage

Similar to other forms of insurance, with vision care you pay a premium and the insurance company will cover part or all of your vision costs.

Preventative care

Vision coverage is important because an eye doctor can catch eye issues before they worsen. A visit with your eye doctor can determine whether you need corrective lenses and, if so, the correct prescription. Other eye concerns that will be addressed in an eye exam include checking for conditions or diseases—such as glaucoma and cataracts—which can lead to vision loss.

Plans

Vision plans typically cover things like eyeglass frames, lenses, contacts and annual eye exams. In most cases, plans have a set dollar amount that they will pay for certain items. For instance, a plan may pay up to $150 for frames, and anything over that amount is covered by you. Although, your plan specifics may vary.

Coverage

Vision coverage does not usually cover surgeries or experimental vision services. However, vision insurance may help lower the costs of some procedures, such as laser eye surgery, even if it's not 100% covered. This will depend on the plan.

Diagnostic care

Eye doctors can even help detect some types of cancer, making regular visits even more important.

Review your benefits statement to see everything your vision plan covers. Reach out to HR with any questions.

Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see in-network providers. Coverage is provided through **Guardian** using the **VSP** provider network.

Find a Provider

- Call **800-357-0978**
- Visit **www.guardiananytime.com**
- Download the mobile app

Vision Summary		
	In-Network You Pay	**Out-of-Network Reimbursement**
Exam	$10	Up to $39
Lenses • Single Vision • Bifocals • Trifocals • Lenticular	 $10 copay $10 copay $10 copay $10 copay	 Up to $23 Up to $37 Up to $49 Up to $64
Frames	$150 allowance + 20% off any remaining balance	Up to $46
Contacts In lieu of frames and lenses • Elective	Up to $150	Up to $46
Benefit Frequency		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts	Once every 12 months	
Employee Per Paycheck Contributions		
Employee	$0.00	
Employee + Spouse	$3.90	
Employee + Child(ren)	$2.72	
Employee + Family	$6.99	

Life and AD&D Insurance

Summary of Coverage

Group Life and AD&D

Life insurance isn't a fun thing to think about, but, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you—your designated beneficiary would collect a financial benefit upon your death.

Group life insurance coverage is an employer-sponsored safety net in case the worst happens, with no out-of-pocket costs to you. If you believe you need additional coverage, you may wish to enroll in voluntary life insurance as well.

Plan Features	Group Life and AD&D
Employee benefit amount	• 1 x annual salary • Minimum $100,000 • Maximum $400,000
AD&D Coverage	• Same as Life amount
Age reduction	• 35% at age 65 • 50% at age 70
Conversion/Portability	• Included

Group life is 100% covered by the employer with the option of employees adding voluntary life

Voluntary Life and AD&D

Employees must fill out an EOI form if they exceed the guaranteed issue amount or didn't enroll as a new hire.

Voluntary life insurance is similar to group life insurance, except it is paid for by you. It can provide additional financial security to you family in case the worst happens.

With voluntary life insurance, you pay a monthly premium and then your beneficiaries receive a guaranteed amount in the event of your death. Plans are typically flexible and allow you to set your contribution and payment amounts, allowing you more control.

While this type of insurance isn't fun to think about, it can be a vital lifeline for your family.

Plan Features	Basic Life - Voluntary
Employee benefit amount	• **Increments of $10,000**
AD&D amount	• **Must match Life amount**
Employee Guarantee Issue (new hires)	• **$100,000**
Spouse benefit amount	• **50% of Employee amount to a max of $100,000**
Spouse Guarantee Issue	• **$30,000**
Dependent benefit amount	• **Birth to 14 days - $500** • **14 days to 26 yrs - $5,000 or $10,000**
Conversion/Portability	• **Included**

[1] Spouse rates are based on employee's age.

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

Disability Insurance

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We provide Short Term Disability (STD) and Long Term Disability (LTD) at no cost to you through **Guardian**.

Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy or non-work related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered Workers' Compensation, not STD.

Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to maximum benefit period.

Short Term Disability	
Employee benefit amount	60% of weekly salary
Maximum benefit amount	Up to $2,500 per week
Elimination period (Accident or Sickness)	13 days
***Pre-Existing Condition**	3/12
Benefit duration	11 weeks

[1] Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

Long Term Disability	
Employee benefit amount	60% of monthly salary
Maximum benefit amount	Up to $15,000 per month *
Elimination period	90 days
Pre-existing Condition Exclusion	3/12[1]
Benefit duration	Social Security Normal Retirement Age

[1] Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

* EOI is needed for amounts over $10,000

Supplemental Insurance

We offer you and your eligible family members the opportunity to enroll in additional coverage through **Guardian** that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses and non-medical related expenses. If you leave your employment, you can take these policies with you.

Hospital Indemnity Insurance

The Hospital Indemnity plan helps you with the high cost of medical care by paying you a set amount when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly based on the care or treatment that you receive. These costs may include meals and transportation, childcare or time away from work due to a medical issue that requires hospitalization.

The chart below only lists a few benefits. See plan document for complete details.

Hospital Indemnity Insurance	
Initial Hospitalization	$1,000
Hospital Confinement	$100 per day

Cancer Insurance

Cancer can be a life-altering diagnosis, and the financial strain that often accompanies it can be overwhelming. Cancer Insurance acts to provide extra financial support in the event of a cancer diagnosis. This benefit helps cover the costs associated with cancer treatment that may not be fully covered by your primary health insurance, such as out-of-pocket expenses, copays, transportation to treatment, and more. With Cancer Insurance, you receive a lump-sum benefit upon diagnosis, as well as ongoing benefits for specific treatments and services related to your care.

Please note, this coverage applies only to **future cancer diagnoses** and not to any existing conditions.

Cancer Insurance	
Employee	$2,500
Spouse	$2,500
Child	$2,500
Cancer Screening	$50 per benefit year
Immunotherapy	$500 per month $2,500 per lifetime
Radiation Therapy and Chemotherapy	$10,000 per benefit year

These products are available on a Voluntary basis and are paid by the employees through payroll deductions. New employees on initial enrollment will have Guarantee Issue. Existing employees will be subject to a health questionnaire on Critical Illness.

Supplemental Insurance

We offer you and your eligible family members the opportunity to enroll in additional coverage through **Guardian** that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses and non-medical related expenses. If you leave your employment, you can take these policies with you.

Accident Insurance

Accident insurance helps offset the direct and indirect expenses resulting from an accident, such as copayments, deductible, ambulance, physical therapy and other costs not covered by traditional health plans.

You have three plans to choose from: Basic, Value, and Advantage.

Accident Insurance	
Emergency Room	$150
Ambulance • Air • Ground	 $750 $150
Initial Hospitalization	$750
Hospital Confinement	$150 per day
Intensive Care Unit	$1,500
Intensive Care Unit Confinement	$300 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$60 - $3,000

Critical Illness Insurance

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses, such as lost income, out-of-town treatments, special diets, daily living and household upkeep costs.

Note, the chart only lists a few of the benefits covered under these plans. See plan document for full details.

Critical Illness Insurance	
Employee	Up to $20,000
Spouse	Up to $10,000
Child	Up to $5,000
First Occurrence Benefit	
Full Coverage Alzheimer's Disease, Invasive Cancer, Heart Attack, Stroke, Heart, Kidney or Organ Failure, Heart Transplant, Coronary Artery Bypass, Type 1 Diabetes, Coma, Paralysis, and more	100% of benefit amount
Partial Coverage Non-invasive Cancer, Metastatic Cancer, Systemic Lupus, Tuberculosis, Addison's Disease, Lyme Disease, Malaria, Encephalitis, Polio, and more	30%-50% of benefit amount
Wellness Benefit One per covered person per calendar year	$50

These products are available on a Voluntary basis and are paid by the employees through payroll deductions. New employees on initial enrollment will have Guarantee Issue. Existing employees will be subject to a health questionnaire on Critical Illness.

Employee Assistance Program

The Employee Assistance Program (EAP) from **Guardian** helps you and family members cope with a variety of personal or work-related issues. This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work/life balance
- Stress and anxiety
- Will preparation and estate resolution
- Grief and loss
- Child and elder care resources
- Substance abuse

Visit **www.worklife.uprisehealth.com** for support at any hour of the day or night.

Click Login to Access and the Code is: **worklife**

Or give them a call directly at **800-386-7055**

Retirement Plan

A 401(k) plan can be a powerful tool to help you be financially secure in retirement. Our 401(k) plan through Ascensus can help you reach your investment goals.

How the Retirement Plan Works

You are eligible to participate in the Plan if you are 18 years of age and have 90 days of service with the company. You may contribute up to the 2026 IRS limit, **$24,500**.

You decide how much you want to contribute and can change your contribution amount anytime. All changes are effective as soon as administratively feasible and remain in effect until you update or stop your contributions. You also decide how to invest the assets in your account and may change your investment choices anytime. For more details, refer to your 401(k) Enrollment Guide or contact **Ascensus** at **866-809-8146**.

Enrollment

You must enroll through **Ascensus** at **www.myaccount.com/GoldmanSachs** or by calling **866-809-8146**

Vesting

You are always 100% vested in your own contributions. You are vested in matching Company contributions according to the following schedule. Refer to your plan's document for further details.

Vesting Schedule

- 1 year of service – 50%
- 2 years of service – 100%
- 3 years of service – 100%
- 4 years of service – 100%
- 5 years of service – 100%

Investment Options

You may direct your contributions to any of the investments offered within the company 401(k) plan. Changes to your investments can be made by calling **866-809-8146**

Legal Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Aspire HR

Jessica Ragsdill

5151 Belt Line Rd.,
Suite 1125
Dallas, TX 75254

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 Aspire HR and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Aspire HR has determined that the prescription drug coverage offered by the Aspire HR medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Aspire HR at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Aspire HR prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **972-372-2820**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

01/01/2026

AspireHR

Human Resources

5151 Belt Line Road Suite 1125

Dallas, TX 75254

Notice of HIPAA Privacy Practices

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

Effective Date of Notice: September 23, 2013

Aspire HR's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Aspire HR

Jessica Ragsdill

5151 Belt Line Rd.,
Suite 1125
Dallas, TX 75254
972-372-2820

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2024. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://www.myalhipp.com/
972-372-2877: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California– Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Georgia – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Indiana – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

Massachusetts – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345 ext.5218

New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

Pennsylvania – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota - Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

Utah – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: https://health.utah.gov/chip
Phone: 1-877-543-7669

Vermont– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

Website: 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/CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

West Virginia – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

Wisconsin – Medicaid and CHIP

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

Wyoming – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since **January 31, 2024**, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Aspire HR group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Aspire HR plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Aspire HR

5151 Belt Line Road Suite 1125

Dallas, TX 75254

972-372-2877

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out- of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of- network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Notes

2026 Employee Benefits Guide

This brochure highlights the main features of the Aspire HR employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Aspire HR reserves the right to change or discontinue its employee benefits plans at any time.

Prepared by Endeavor Risk Advisors for AspireHR.