2026

EMPLOYEE BENEFITS GUIDE

for a healthy you

THOMAS EDWARDS GROUP

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

September 1, 2026

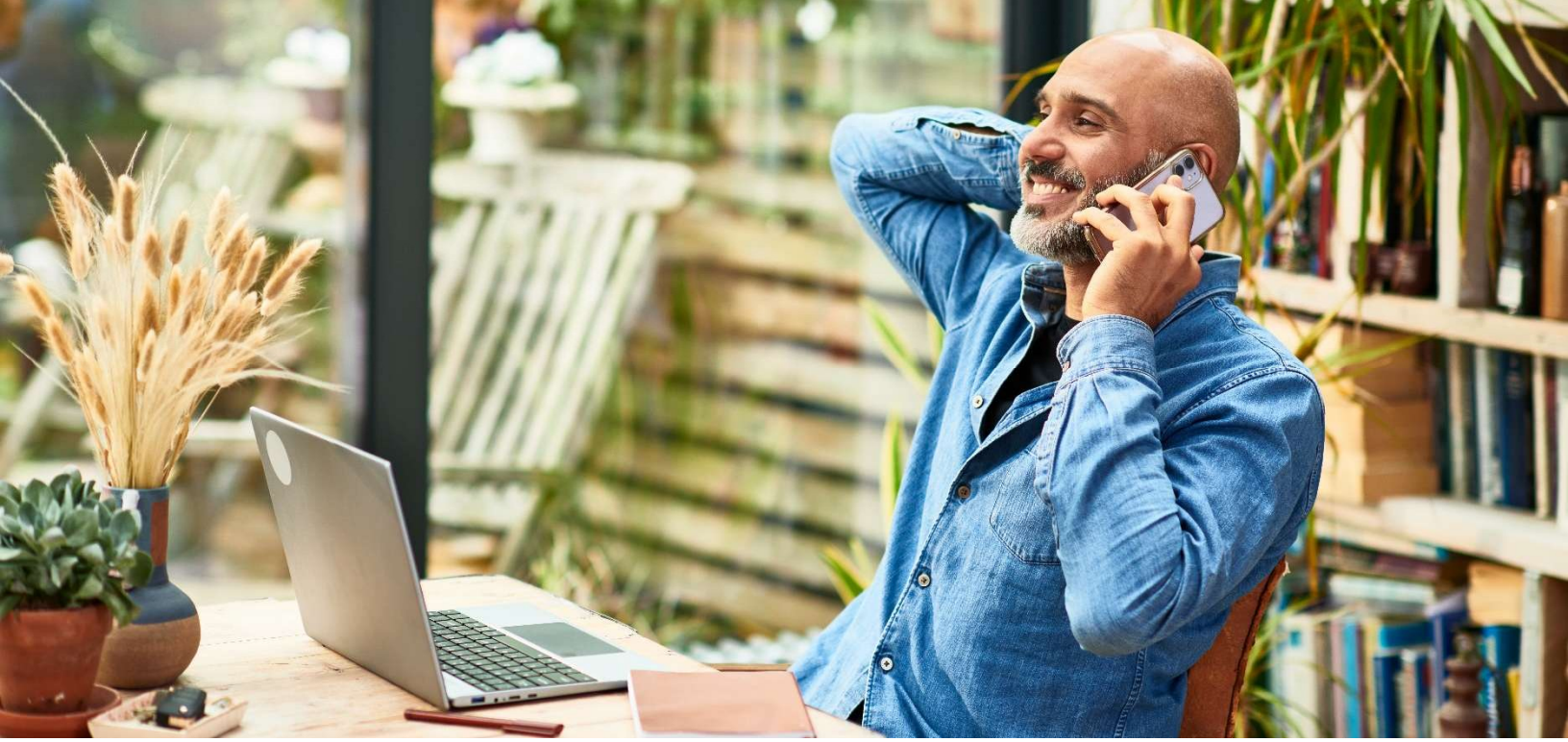
AND CONTINUE THROUGH

August 31, 2027

Contents

3 Important Contacts
4 Eligibility
5 Enrollment/Information
6 Employee Help Desk
7 Medical Coverage
13 BCBS Resources/Networks
15 HSA Bank
16 Health Care Options
17 Dental Coverage
19 Vision Coverage
21 Disability Insurance
22 Employee Assistance Program
23 Telemedicine
28 Legal Notices

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 27 for more details.



Important Contacts

Plan	Provider	Group No.	Phone	Website/Email
Medical	BlueCross BlueShield	Pending	800-521-2227	www.bcbstx.com
Dental	BlueCross BlueShield	Pending	800-521-2227	www.bcbstx.com
Vision	BlueCross BlueShield	Pending	888-657-6061	www.bcbstx.com
Disability	Unum	00498285	866-679-3054	www.unum.com
Telemedicine	Freshbenies	BENIES4867	888-813-5468	www.freshbenies.com
HSA Bank	HSA Bank		800-357-6246	www.hsabank.com
Benefits Specialist	Endeavor Risk Advisors Lisa Burkham, Sr. Acct Mgr.		972-220-0895	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 30 days of your start date

when coverage starts

- First of the month following 60 days

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

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

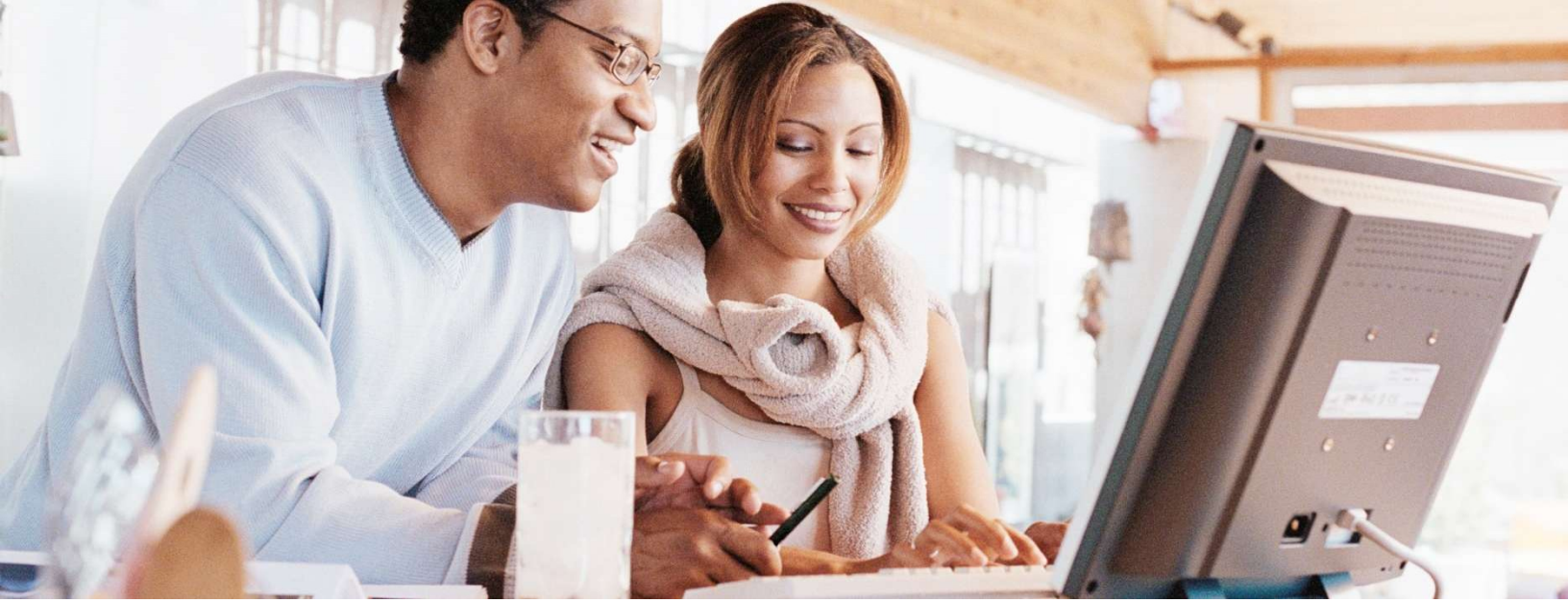
Qualifying Life Events

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 & Important Information

Enrollment

1	All eligible employees will need to completed the attached enrollment form to either elect or waive benefits.
2	Once completed, you will load your enrollment form into Dropbox. Here is the link you will use: https://www.dropbox.com/request/pn0qstvyl0lmy7pucbk7

Important Information

1	Open Enrollment meetings will be August 5th. Deadline to submit your enrollment form will be August 12th.
2	Benefits will begin on September 1st.
3	If you leave Thomas Edwards Group, your Medical, Dental and Vision coverage will end the last day of the month in which you worked. STD, LTD & Freshbenies will end the last day worked.
4	If you have met any deductible since January 1st, BCBS will allow a one-time deductible credit on the new plan. You will need to upload in the Dropbox your last explanation of benefits from UHC showing deductible met to date for each person you cover. Remember that deductibles and Out of Pocket max start over each January 1st.

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:

- Blue Choice PPO – MTBCB614
- Blue Choice PPO – HDHP – MTBCP007H
- Blue Essentials HMO – MTBEE628
- Blue Premier Access HMO – HDHP – MTBPA007H

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.

Health Maintenance Organization (HMO)

An HMO requires you to use doctors, hospitals, and providers within the plan's network for covered care. You'll typically choose a primary care physician (PCP) who coordinates your care and provides referrals to specialists. Care received from in-network providers is usually covered with lower out-of-pocket costs, while out-of-network care is generally not covered except for emergencies. Office visits, urgent care, and prescription drugs are often covered with a copay, and other covered services may apply toward your deductible and coinsurance.

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 includes regular physical examinations, mammograms and immunizations. Through the plans offered by Thomas Edwards 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 childcare
- 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 Option 1

	BlueCross BlueShield MTBCB614	
Provider Network	Blue Choice PPO	
	In-Network	**Out-of-Network**
Deductible • Individual • Family	$1,500 $4,500	$3,000 $9,000
Out-of-Pocket Maximum • Individual • Family	$6,000 $18,000	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited
General Level of Coverage	70%	40%
	You Pay	
Preventive Care	No Charge	40%[1]
Primary Care Physician(not required)	$40 copay	40%[1]
Specialist	$80 copay	40%[1]
Diagnostic Lab and X-ray	20%[1]	40%[1]
Complex Imaging	20%[1]	40%[1]
Urgent Care	$75 copay	40%[1]
Emergency Room	$750 plus 20%[1]	
Inpatient Hospital Services	20%[1]	40%[1]
Outpatient Services	$100 copay, 20%[1]	40%[1]
Prescription Drugs – Retail Up to 30-day supply • Generic • Preferred brand name • Non-preferred brand name • Specialty	 $0 / $10 $50 $100 $150 / $250	 Copay +50% Copay +50% Copay +50% Copay +50%
Employee Per Paycheck Contributions		
Employee	$148.16	
Employee + Spouse	$629.02	
Employee + Child(ren)	$311.22	
Employee + Family	$792.08	

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

Medical Plan Option 2

	BlueCross BlueShield MTBCP007H (*HDHP)	
Provider Network	Blue Choice PPO	
	In-Network	**Out-of-Network**
Deductible ● Individual ● Family	$5,000 $10,000	$10,000 $20,000
Out-of-Pocket Maximum ● Individual ● Family	$5,000 $10,000	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited
General Level of Coverage	100%	70%
	You Pay	
Preventive Care	No Charge	30%[1]
Primary Care Physician (not required)	0%[1]	30%[1]
Specialist	0%[1]	30%[1]
Diagnostic Lab and X-ray	0%[1]	30%[1]
Complex Imaging	0%[1]	30%[1]
Urgent Care	0%[1]	30%[1]
Emergency Room	0%[1]	
Inpatient Hospital Services	0%[1]	30%[1]
Outpatient Services	0%[1]	30%[1]
Prescription Drugs – Retail Up to 30-day supply ● Generic ● Preferred brand name ● Non-preferred brand name ● Specialty	 0%[1] 0%[1] 0%[1] 0%[1]	 50%[1] 50%[1] 50%[1] 50%[1]
Employee Per Paycheck Contributions		
Employee	$118.02	
Employee + Spouse	$501.07	
Employee + Child(ren)	$247.91	
Employee + Family	$630.95	

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

* This plan is eligible for an HSA bank account.

Medical Plan Option 3

	BlueCross BlueShield MTBEE628	
Provider Network	*Blue Essentials HMO	
	In-Network	**Out-of-Network**
Deductible • Individual • Family	$3,000 $9,000	N/A N/A
Out-of-Pocket Maximum • Individual • Family	$9,000 $18,000	N/A
Lifetime Maximum Benefit	Unlimited	N/A
General Level of Coverage	80%	N/A
	You Pay	
Preventive Care	No Charge	N/A
Primary Care Physician (required)	$40 copay	N/A
Specialist	$80 copay	N/A
Diagnostic Lab & X-ray	20%[1]	N/A
Complex Imaging	20%[1]	N/A
Urgent Care	$75 copay	N/A
Emergency Room	$750 plus 20%[1]	
Inpatient Hospital Services	20%[1]	N/A
Outpatient Services	$100 copay, 20%[1]	N/A
Prescription Drugs – Retail Up to 30-day supply • Generic • Preferred brand name • Non-preferred brand name • Specialty	$0 / $10 $50 $100 $150 / $250	N/A
Employee Per Paycheck Contributions		
Employee	$90.03	
Employee + Spouse	$382.21	
Employee + Child(ren)	$189.10	
Employee + Family	$481.28	

*Blue Essentials is an HMO network, and you must live in Texas to enroll in this plan.

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

Medical Plan Option 4

	BlueCross BlueShield MTBPA007H (*HDHP)	
Provider Network	*Blue Premier Access HMO	
	In-Network	**Out-of-Network**
Deductible ● Individual ● Family	$5,000 $10,000	N/A N/A
Out-of-Pocket Maximum ● Individual ● Family	$5,000 $10,000	N/A
Lifetime Maximum Benefit	Unlimited	N/A
General Level of Coverage	100%	N/A
	You Pay	
Preventive Care	No Charge	N/A
Primary Care Physician (not required)	0%[1]	N/A
Specialist	0%[1]	N/A
Diagnostic Lab & X-ray	0%[1]	N/A
Complex Imaging	0%[1]	N/A
Urgent Care	0%[1]	N/A
Emergency Room	0%[1]	
Inpatient Hospital Services	0%[1]	N/A
Outpatient Services	0%[1]	N/A
Prescription Drugs – Retail Up to 30-day supply ● Generic ● Preferred brand name ● Non-preferred brand name ● Specialty	0%[1] 0%[1] 0%[1] 0%[1]	N/A
Employee Per Paycheck Contributions		
Employee	$73.58	
Employee + Spouse	$312.37	
Employee + Child(ren)	$154.55	
Employee + Family	$393.34	

*Blue Premier Access is an HMO narrow network, and you must live in Texas and in one of the covered counties to enroll in this plan. Counties include:

Denton, Collin, Tarrant, Dallas, Rockwall, Johnson, Ellis, Bell, Williamson, Travis, Hays, Comal, Bexar, Atascosa, Kendall, Bandera, Guadalupe, Montgomery, Harris, Fort Bend, Liberty, Hardin, Orange, Jefferson and Chambers.

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

* This plan is eligible for an HSA bank account

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 **800-631-7023** 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.

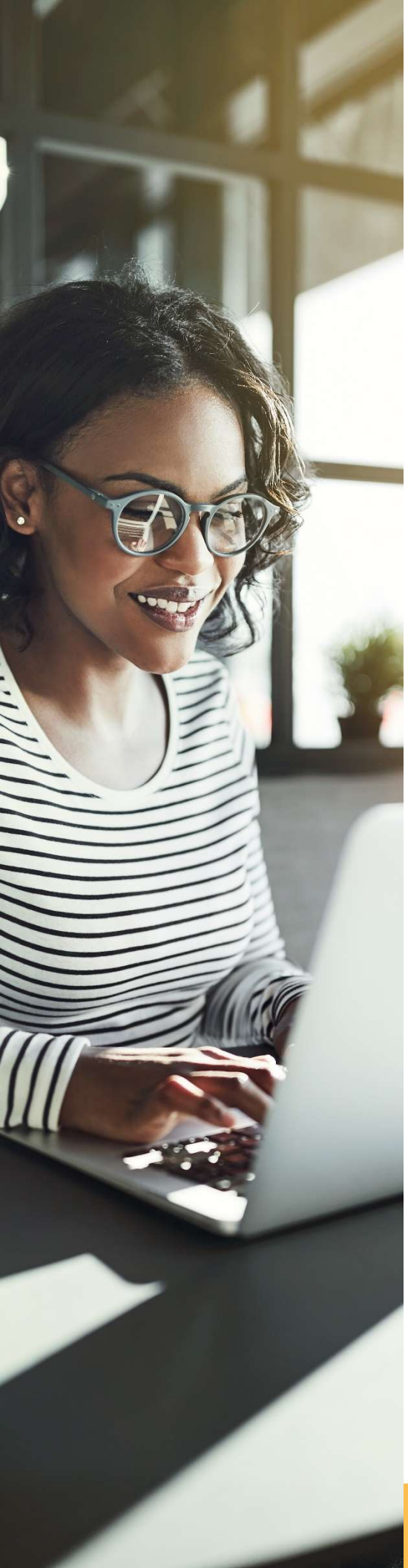
Coverage While Traveling

Travel with confidence, knowing that you can receive care while away. Learn more about this program that's included in your plan. It keeps you covered when traveling across the country or around the world. Travel with Bluecard.

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



BCBSTX Network Search

Welcome to your new health plan!
Here's what you need to know to make the most of your BlueCross BlueShield of Texas (BCBSTX) **PPO & HMO plans**.

Finding In-Network Doctors

- Visit **bcbstx.com** → "Find Care" → "Find a Doctor or Hospital."
- Check that your PCP, specialists, and hospitals are **in the Blue Choice PPO network, Blue Essentials or Blue Premier Access HMO networks**.
- Always use in-network providers to avoid surprise bills.

How Your Blue Choice PPO Plan Works

- **Primary Care Physician (PCP):**

You are not required to select a PCP with the PPO plan. However, having a PCP as your main doctor can help manage your care.

- **Referrals Not Required:**

Need to see a specialist? You do not need a **referral** to an in-network specialist.

- **In-Network Only:**

PPO plans cover services from both **in & out-network doctors and hospitals.** To keep cost lower, seek in-network care.

How Your Blue Essentials HMO Plan Works

- **Choose a Primary Care Physician (PCP):**

Pick a doctor from the BCBSTX HMO network. Your PCP will be your main doctor and will help manage your care. You will need the PCP ID number when enrolling.

- **Referrals Required:**

Need to see a specialist? Your PCP will give you a **referral** to an in-network specialist.

- **In-Network Only:**

HMO plans only cover services from **in-network doctors and hospitals**, except in an **emergency**.

How Your Blue Premier Access HMO Plan Works

- **Primary Care Physician (PCP):**

You are not required to select a PCP with this HMO plan. However, having a PCP as your main doctor can help manage your care.

- **Referrals Not Required:**

Need to see a specialist? You do not need a **referral** to an in-network specialist.

- **In-Network Only:**

HMO plans only cover services from **in-network doctors and hospitals**, except in an **emergency**.

Health Savings Account

For Plans MTBCP007H & MTBPA007H only

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.

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**.

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.

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.

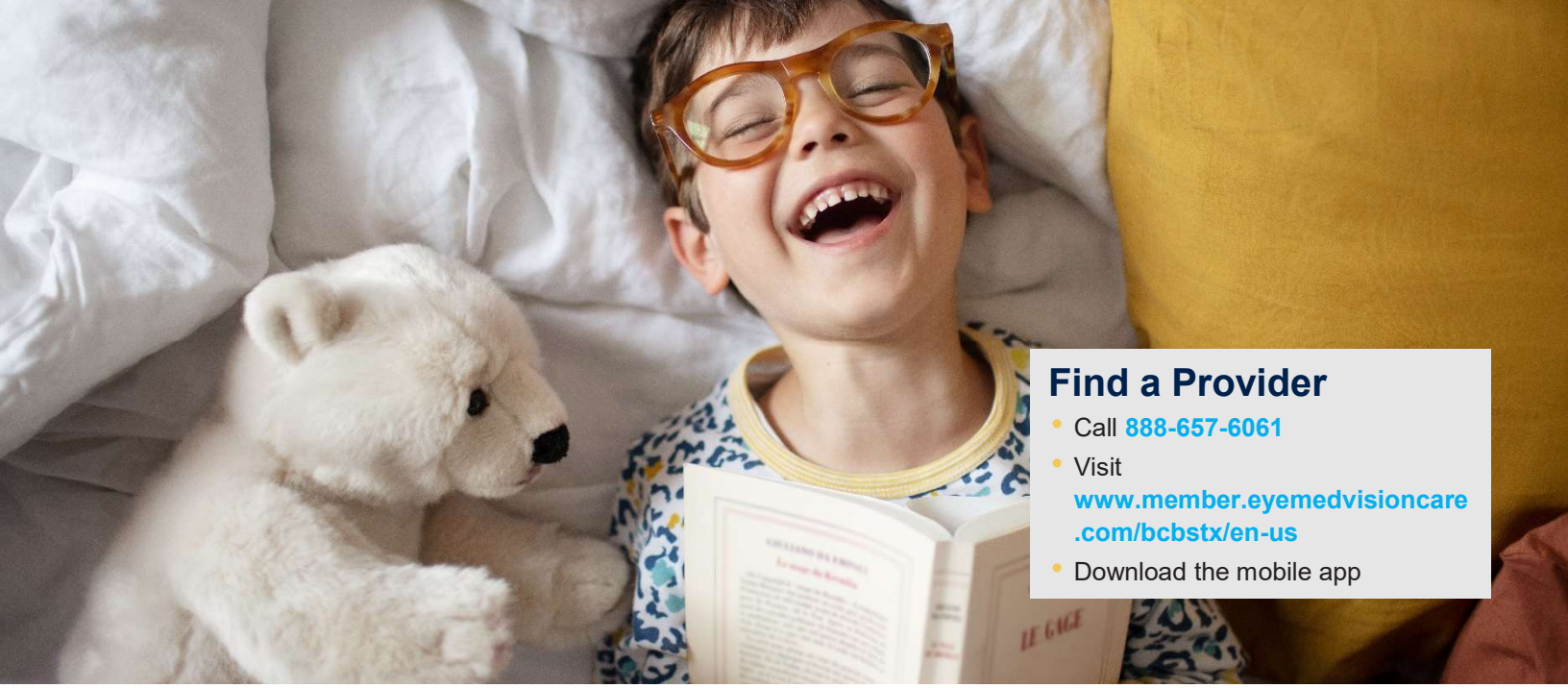
See everything your plan covers by reviewing the benefits statement and overview. Reach out to HR with any questions.

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 within network providers. Out of network providers may balance bill you. Your Network is BlueCare Dental.

	DTNLM38	
	In-Network	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $50 $150	 $50 $150
Calendar Year Benefit Maximum Per Individual	$1,500	$1,500
	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, Periodontal	20% after deductible	20% after deductible
Major Restorative Crowns, Bridge work, Dentures	50% after deductible	50% after deductible
Orthodontia (dependent children under 19)	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000
Employee Per Paycheck Contributions		
Employee	$15.73	
Employee + Spouse	$31.45	
Employee + Child(ren)	$40.38	
Employee + Family	$61.77	



Find a Provider

- Call **888-657-6061**
- Visit **www.member.eyemedvisioncare.com/bcbstx/en-us**
- Download the mobile app

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 **BCBS of Texas** using the **EyeMed** provider network.

Vision Summary		
	In-Network You Pay	**Out-of-Network Reimbursement**
Exam	$10	Up to $30
Lenses • Single Vision • Bifocals • Trifocals • Lenticular	 $25 copay $25 copay $25 copay $25 copay	 Up to $25 Up to $40 Up to $55 Up to $55
Frames	$130 allowance + 20% off any remaining balance	Up to $65
Contacts In lieu of frames and lenses • Elective	$130 allowance	Up to $104
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	$3.80	
Employee + Spouse	$7.22	
Employee + Child(ren)	$7.60	
Employee + Family	$11.17	

Disability Insurance

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

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.

Short Term Disability – Voluntary Plan	
Employee benefit amount	60% of weekly salary
Maximum benefit amount	Up to $1,500 per week
Elimination period (Accident/Sickness)	0 days/7 days
Benefit duration	13 weeks

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.

Long Term Disability – Group Plan	
Employee benefit amount	60% of monthly salary
Maximum benefit amount	Up to $6,000 per month
Elimination period	90 days
Pre-existing Condition Exclusion	3/12[1]
Benefit duration	Social Security Normal Retirement Age

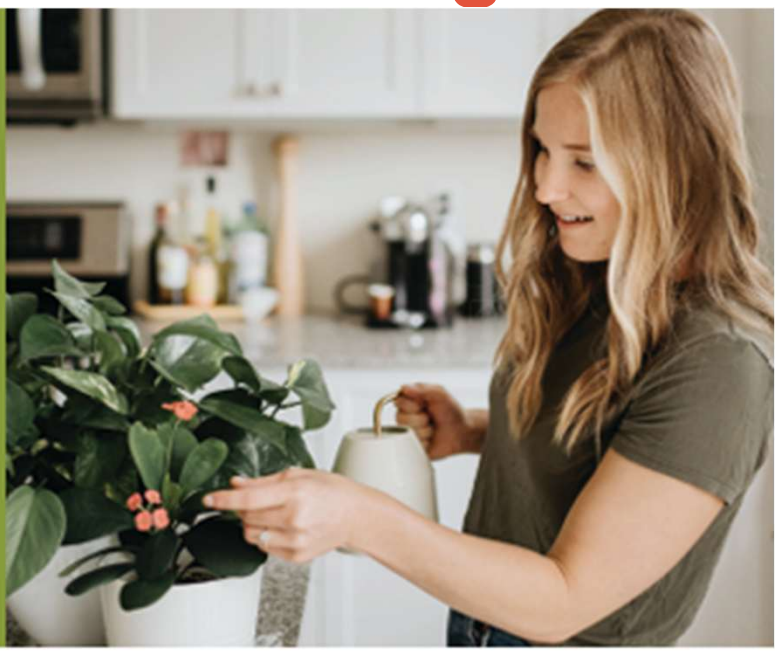
[1] Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

Employee Assistance Program

unum

Help, when you need it most

With your Employee Assistance Program and work-life balance services, confidential assistance is as close as your phone or computer.



Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief, loss
- Job stress, work conflicts
- Family, parenting problems
- And more

Work-life balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our work-life Specialists can answer your questions and help you find resources in your community.

Ask our work-life Specialists about:

- Child care
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions**
- Even reducing your medical/dental bills
- And more

Who is covered?

EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver® — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Better benefits at work.™

unum.com

*The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

**State mandated limitations apply for work-life balance employee assistance program services in WA.

Work-life balance employee assistance programs may not be available in New York. Other state-specific restrictions may apply based on the product offering.

The Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

EN-205814 FOR EMPLOYEES (5-25)

THOMAS EDWARDS GROUP

Provides

freshbenies®

As a FREE Benefit to You & Your family

Program Highlights:

24/7 Telehealth at No Cost -
Employees, their spouse, and children under age 26 have access to free telehealth services 24 hours a day, 365 days a year with no copays. Members can speak with a doctor anytime for common medical concerns without needing to visit an urgent care clinic or doctor's office.

Healthcare Advocacy and Guidance -
Freshbenies includes a dedicated advocacy service to help simplify the healthcare process. Advocates assist with finding quality doctors, reviewing medical bills, locating the best place for procedures, tests, or medications, and providing overall healthcare guidance to help members save time and money.

Behavioral Telehealth Services -
Members have access to behavioral health support through virtual visits with licensed therapists for $85 visit fee and psychiatrists at a $95 visit fee. ($225 initial intake) This benefit makes mental health care more accessible and convenient for employees and their families.

$0 Prescription Program -
The Freshbenies prescription program provides access to more than 1,400 medications at no cost, including 95% of the top 200 most prescribed medications. Prescriptions can be filled at over 60,000 pharmacies nationwide, making it easy and convenient to save on medications.

freshbenies

Telehealth

Your 24/7/365 Dr. BFF!

Did you know up to 70% of medical issues can be solved over the phone? Call a doctor (U.S.-based) anytime, & get a prescription written, if medically needed. No visit fee when you call...no kidding!

Overview

Feel better now! 24/7 access to a doctor is only a call or click away—anytime, anywhere with no visit fee. Talk to a U.S. licensed physician by phone or video to get a diagnosis, treatment options and a prescription, if medically necessary. Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or ER.

- Unlimited visits with no per visit fee
- Includes the immediate family - children to seniors
- U.S. board-certified doctors
- 10 minute average doctor response time
- Treatment for common medical issues such as colds, flu, respiratory infections, bronchitis, pink eye, poison ivy, sinus problems, allergies, urinary tract infections and ear infections
- Get a doctor's note for school or work

Advocacy

Your friend in the insurance industry!

How much will your medical procedure cost? Where can you find a quality provider? Were you billed correctly? Call your personal Advocate to get answers to these questions, negotiate bills on your behalf and more.

Overview

Healthcare is confusing, medical costs are rising, and finding the right care for you and your family can be frustrating and time consuming. Your Advocate will simplify your healthcare experience and help you take control of healthcare costs.

These services are separate from your health plan, so you can have confidence that referrals, bill reviews and overall guidance are not influenced by outside factors.

Use your Advocacy service to help you...

- Clarify benefits
- Answer questions about tests, treatments and medications
- Coordinate care among multiple providers
- Assist with eldercare and related healthcare issues
- Arrange second opinions
- Transfer medical records
- Find options for non-covered services
- Provide information about generic drug options
- Untangle medical bills and insurance claims

freshbenies®
A FRESH APPROACH TO BENEFITS

Zero Rx:
Your prescription for $0 medication

Pay $0 for 1400+ commonly prescribed acute and chronic care prescriptions - for you and your family. No copay, no deductible, no kidding.

Here's how it works:

- Log into your freshbenies app or portal and select the Zero Rx icon
- Search the Zero Rx list to see if your drug is available for $0
- If yes, use Find a Pharmacy to locate a provider near you (includes national chains and local neighborhood pharmacies)
- Show your digital Zero Rx card to the pharmacist at check out
  TIP: Tell the pharmacist this is a prescription plan, not a discount program.

Includes 95% of top 200 prescriptions - available at 60,000 pharmacies nationwide

Metformin (diabetes) **Atorvastatin (cholesterol)**
Amoxicillin (antibiotic) Lisinopril (blood pressure)
Sertraline (depression/anxiety)
AND MORE!

Scan for the full list of 1400+ prescriptions

Q&A About Using Your Zero Rx Service

Q: Who can use Zero Rx?
Answer: You, your spouse and all IRS dependents are included in your freshbenies membership - even if they aren't on your medical plan.

Q: Where can I fill my Zero Rx prescriptions?
Answer: At over 60,000 retail pharmacies nationwide - including large retail chains of grocery stores, Walgreens, CVS, Costco and local neighborhood pharmacies.

From your freshbenies app and portal, open Zero Rx and select Find a Pharmacy to find an option near you.

Q: Is Zero Rx a discount program?
Answer: No. When you show your Zero Rx card at the pharmacy, tell them this is a prescription plan - it is NOT a discount program.

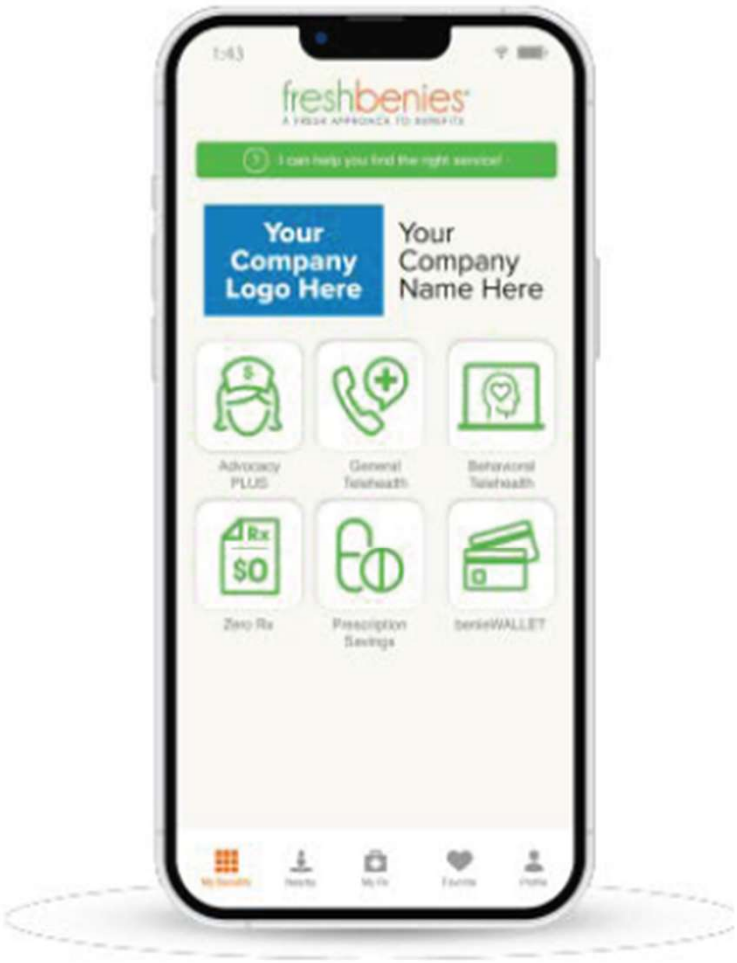
Q: Do I need to use insurance?
Answer: No. Zero Rx is totally separate from any insurance. This service gives you access to $0 prescriptions outside of your medical plan.

Q: Is there a cost to use Zero Rx?
Answer: No. There's no extra cost to you - it's included in your freshbenies membership.

Q: Do prescriptions on the Zero Rx list change?
Answer: Yes, but only one time a year. Typically, 20 or fewer changes will occur in the annual update based on current market trends.

Q: I see some over-the-counter medications on the Zero Rx list. Do I need a doctor's prescription to pay $0?
Answer: Yes. If your doctor advises you to use an over-the-counter medication that is on the Zero Rx list, ask for a prescription so you can pay $0 at the pharmacy.

Q: What should I do if my medication isn't on the Zero Rx list?
Answer: You can still save! Use your Prescription Savings service to find the best price at a local pharmacy near you.



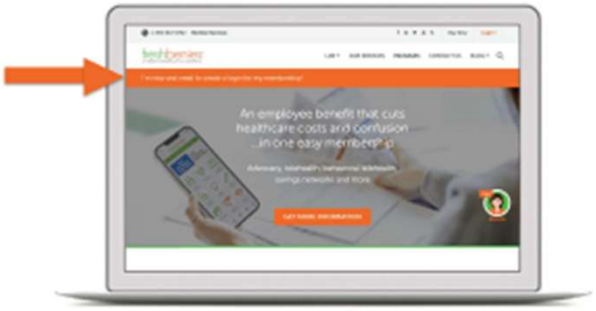
Download the freshbenies app to put all your services at your fingertips

3 STEPS to use your services

freshbenies®
A FRESH APPROACH TO BENEFITS

1 Activate your membership

Simply visit freshbenies.com and click the "I'm new" banner to create your login.



2 Explore all your services in your app or portal

Scan QR code to download the app. Then tap any service icon to see how it works.

3 Use your benies & save

Your freshbenies membership includes your immediate family so have them download the app, too!

Now you're ready to cut healthcare costs & confusion!

This is not Insurance and is not intended to replace insurance.

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:

Thomas Edwards Group

Lisa Kilgore

15770 N. Dallas
Parkway, STE 950
Dallas, TX 75248

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 Thomas Edwards Group 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. Thomas Edwards Group has determined that the prescription drug coverage offered by the Thomas Edwards Group 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 Thomas Edwards Group 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 Thomas Edwards Group 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 **214-624-7938**.

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

Thomas Edwards Group

Human Resources

15770 N Dallas Parkway, STE 950

Dallas, TX 75248

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

Thomas Edwards Group'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:

Thomas Edwards Group

Lisa Kilgore

15770 N. Dallas
Parkway, STE 950
Dallas, TX 75248
214-624-7938

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/
214-624-7938: 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 Thomas Edwards Group group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Thomas Edwards Group 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

Thomas Edwards Group

15770 N Dallas Parkway, STE 950

Dallas, TX 75248

214-624-7938

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.

2026 Employee Benefits Guide

This brochure highlights the main features of the Thomas Edwards Group 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. Thomas Edwards Group reserves the right to change or discontinue its employee benefits plans at any time.

Prepared by Endeavor Risk Advisors for Thomas Edwards Group.