

2026 EMPLOYEE BENEFITS



DMooney
ENTERPRISES

TRAVELING NURSE

HELPFUL RESOURCES

IMPORTANT CONTACTS

Medical Coverage
UnitedHealthcare
866-801-4409
www.myuhc.com

UHC 24/7 Virtual Visits
UnitedHealthcare
www.myuhc.com/virtualvisits

Health Savings Account
HSA Bank
www.hsabank.com
800-357-6246

Dental Coverage
MetLife
www.metlife.com
800-GET-MET8 (800-438-6388)

Vision Coverage
MetLife
www.metlife.com/vision
855-MET-EYE1 (638-3931)

Life and AD&D Insurance
MetLife
www.metlife.com
800-638-5000

Flexible Spending Accounts
Higginbotham
https://flexservices.higginbotham.net
flexclaims@higginbotham.net
866-419-3519

Disability Insurance
MetLife
www.metlife.com
800-858-6506

Accident Insurance
MetLife
www.metlife.com
800-GET-MET8 (800-438-6388)

Hospital Indemnity Insurance
MetLife
www.metlife.com
800-GET-MET8 (800-438-6388)

Critical Illness Insurance
MetLife
www.metlife.com
800-GET-MET8 (800-438-6388)

Human Resources
Donald L Mooney Enterprises
Yolanda McIntyre
ymcintyre@nursesetc.net



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 24 for more details.

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WELCOME AND ELIGIBILITY

We are pleased to offer a full benefits package to help protect your well-being and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting January 1, 2026.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through December 31, 2026. Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

ELIGIBILITY

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective the first of the month after you have completed 30 days of full-time employment. You may also enroll eligible dependents for benefits coverage. The cost for coverage depends on the number of dependents you enroll and the benefits you choose. When covering dependents, you must select and be on the same plans.

Eligible Dependents Include

- Your legal spouse
- Children under the age of 26 regardless of student, dependency, or marital status
- Children over the age of 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

Qualifying Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event (QLE), some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or child
- FMLA leave, COBRA event, judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order

If you have a QLE and want to change your elections, you must notify Human Resources and complete your changes within 30 days of the event. You may be asked to provide documentation to support the change. Contact Human Resources for specific details.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Your benefits program offers four medical plan coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) for each plan is available at **www.myuhc.com**.

MEDICAL COVERAGE

The medical plan options through **UnitedHealthcare (UHC)** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of four plans:

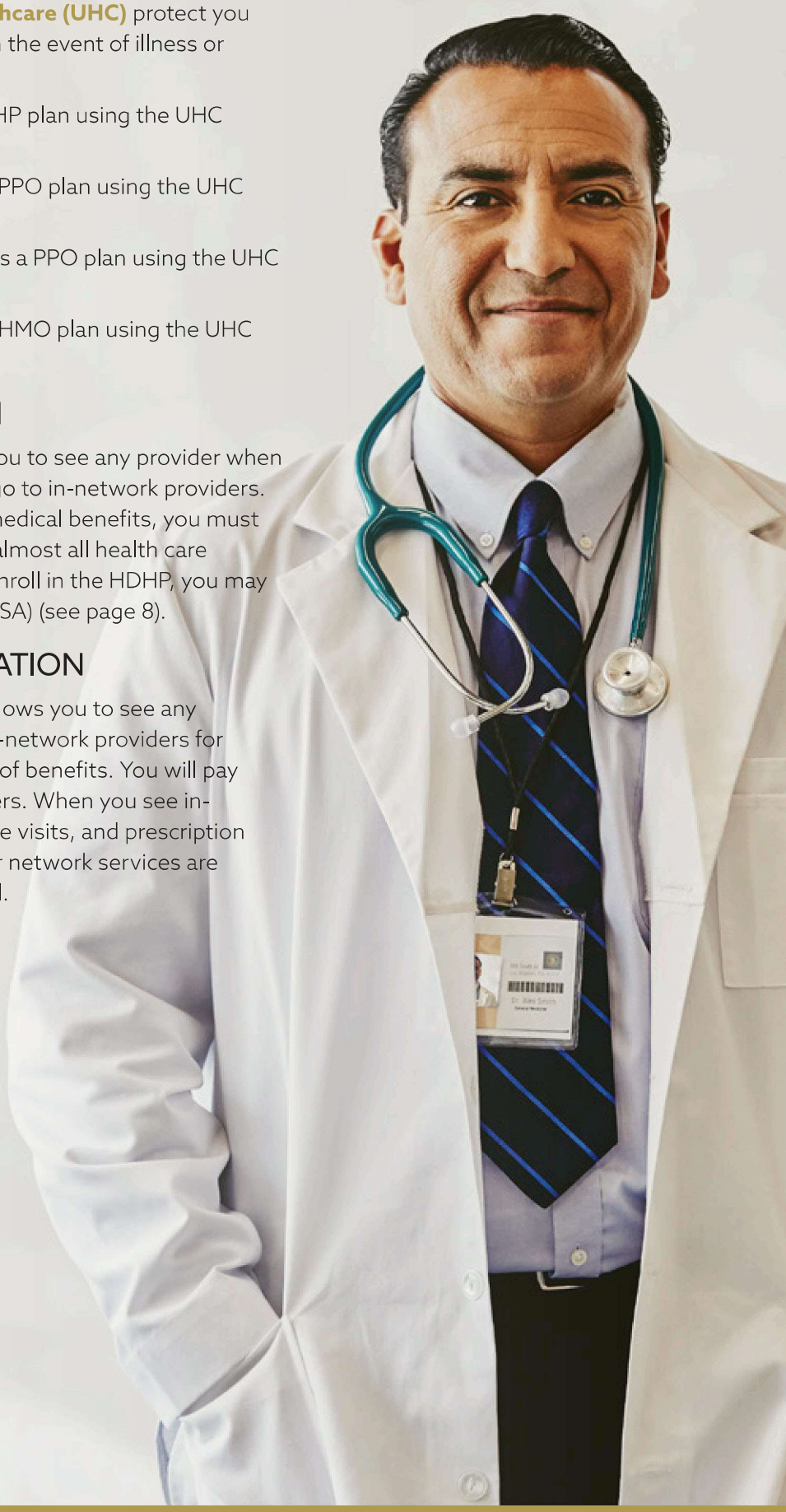
- **UHC HDHP/HSA (EITO-MM)** - This is an HDHP plan using the UHC Choice Plus Network.
- **UHC BASE COPAY PLAN (EI1J-EJ)** - This is a PPO plan using the UHC Choice Plus Network.
- **UHC BUY-UP COPAY PLAN (EIXF-EJ)** - This is a PPO plan using the UHC Choice Plus Network.
- **UHC NAVIGATE PLAN (EIUX-EJ)** - This is an HMO plan using the UHC Navigate Network.

HIGH DEDUCTIBLE HEALTH PLAN

A High Deductible Health Plan (HDHP) allows you to see any provider when you need care, but you will pay less when you go to in-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 prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (HSA) (see page 8).

PREFERRED PROVIDER ORGANIZATION

A Preferred Provider Organization (PPO) plan 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 out-of-network providers. When you see in-network providers, your office visits, urgent care visits, and prescription drugs are covered with a copay, and most other network services are covered at the deductible and coinsurance level.



FIND A NETWORK PROVIDER

- Visit **www.myuhc.com**
- Call **866-801-4409**

MEDICAL COVERAGE

MEDICAL BENEFITS SUMMARY

	UHC HDHP/HSA EITO-MM		UHC BASE COPAY PLAN EI1J-EJ	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $6,750 $13,500	 $10,000 $20,000	 $3,000 $6,000	 $7,500 $15,000
Calendar Year Out-of-Pocket Maximum Includes deductible • Individual • Family	 $6,750 $13,500	 $20,000 $40,000	 $7,150 $14,300	 $15,000 $30,000
	You Pay		**You Pay**	
Preventive Care	$0	30% after deductible	$0	50% after deductible
UHC Virtual Visits	$54 copay or less	30% after deductible	$54 copay or less	50% after deductible
Primary Care Physician	$0 after deductible	30% after deductible	$10 copay	50% after deductible
Specialist	$0 after deductible	30% after deductible	$40/$80 copay[1]	50% after deductible
Urgent Care	$0 after deductible	30% after deductible	$25 copay	50% after deductible
Diagnostic X-ray and Lab	$0 after deductible	30% after deductible	$40 copay	50% after deductible
Complex Imaging CT/PET scan, MRI	$0 after deductible	30% after deductible	$500 copay	50% after deductible
Emergency Room	$0 after deductible		$300 copay then 20% after deductible	
Inpatient Hospital Services	$0 after deductible	30% after deductible	20% after deductible	50% after deductible
Outpatient Services	$0 after deductible	30% after deductible	20% after deductible	50% after deductible
Prescription Drugs Retail Up to a 31-day supply • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $0 after deductible $0 after deductible $0 after deductible Not covered	 $0 after deductible $0 after deductible $0 after deductible Not covered	 $15 copay $45 copay $85 copay $200 copay	 $15 copay $45 copay $85 copay $200 copay
Prescription Drugs Mail Order 90-day supply • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $0 after deductible $0 after deductible $0 after deductible Not covered	 Not covered Not covered Not covered Not covered	 $37.50 $112.50 $212.50 $500 copay	 Not covered Not covered Not covered Not covered

[1] The amount you pay at a designated in-network provider versus a non-designated in-network provider.

MEDICAL COVERAGE

MEDICAL BENEFITS SUMMARY

	UHC BUY-UP COPAY PLAN EIXF-EJ		UHC NAVIGATE PLAN EIUX-EJ (Texas Residents Only)
	In-Network	**Out-of-Network**	**In-Network Only**
Calendar Year Deductible • Individual • Family	$1,500 $3,000	$5,000 $10,000	$1,000 $2,000
Calendar Year Out-of-Pocket Maximum Includes deductible • Individual • Family	$5,000 $10,000	$10,000 $20,000	$6,600 $13,200
	You Pay		**You Pay**
Preventive Care	$0	50% after deductible	$0
UHC Virtual Visits	$54 copay or less	50% after deductible	$54 copay or less
Primary Care Physician	$25 copay	50% after deductible	$25 copay
Specialist	$25/$50 copay[1]	50% after deductible	$75 copay
Urgent Care	$50 copay	50% after deductible	$50 copay
Diagnostic Lab and X-ray	$0	50% after deductible	20% after deductible
Complex Imaging CT/PET scan, MRI	20% after deductible	50% after deductible	$500 copay
Emergency Room	$500 copay then 20% after deductible		$500 copay
Inpatient Hospital Services	20% after deductible	50% after deductible	20% after deductible
Outpatient Services	20% after deductible	50% after deductible	20% after deductible
Prescription Drugs Retail Up to a 31-day supply • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $15 copay $45 copay $85 copay $200 copay	 $15 copay $45 copay $85 copay $200 copay	 $15 copay $45 copay $85 copay $200 copay
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[1] The amount you pay at a designated in-network provider versus a non-designated in-network provider.

MEDICAL COVERAGE

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is provided through **UHC**.

Prescription Drug List

UHC controls prescription drug costs by negotiating discounts on medications. Drugs included in the **UHC Prescription Drug List (PDL)** are classified in tiers – the different cost levels you pay for a medication. Tier 1 medications are the lowest-cost options. If your medication falls within tier 2 or 3, discuss with your doctor if there is a tier 1 alternative.

- **Tier 1** – Lowest-cost medications
- **Tier 2** – Midrange cost medications
- **Tier 3** – Highest-cost medications

If your medication is not listed here, call the phone number on your member ID card.

Retail and Home Delivery

Use a retail pharmacy or home delivery for non-specialty medications. Home delivery is a convenient, low-cost option for long-term medications to treat chronic conditions like diabetes and heart disease.



PHARMACY DISCOUNTS

Use **Optum Perks** to get discounts on prescription drugs so you do not overpay for medications. This service is free and does not require membership. Visit **https://perks.optum.com** or download the free **Optum Perks app** to get discounts.

- **Search**. Type in your drug name(s).
- **Find** the best price. See prices from pharmacies near you to get the best discount.
- **Get** your coupons. Print, email, or text the coupon.
- **Show** the coupon to your pharmacist.

Specialty Medications

Use **Optum Specialty Pharmacy** for specialty drugs to treat complex or chronic conditions. Call **855-427-4682** to speak to a pharmacist or patient care coordinator, who can help with new or transfer orders and specialty medication support, including virtual visits. Specialty medications can only be filled through Optum. Certain exclusions and limitations apply.

To access information on drugs included under the UHC PDL, log in at **www.myuhc.com** or use the **UnitedHealthcare mobile app**. The following information and tools are available:

- Pharmacy benefit and coverage information
- Suggestions for lower-cost medication alternatives
- Medications list based on specific medical conditions
- Medication interactions and side effects
- Locate a participating retail pharmacy
- Manage mail order prescriptions
- View your prescription history
- Refill prescriptions
- Check the status of an order
- Set up email reminders for refills
- Manage your account

Certain drugs require prior authorization, step therapy, or may have dispensing limits or other coverage requirements.

HEALTH SAVINGS ACCOUNT

An HSA is more than a way to help you and your family cover current medical costs — it is also a tax-exempt tool to supplement your retirement savings and to cover future health costs. **HSA Bank** is our plan administrator.

As 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 (UHC HDHP/HSA EITO-MM)
- 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.

MAXIMUM CONTRIBUTIONS

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

- **Individual** – $4,400
- **Family** – $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 age 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. Visit **www.hsabank.com** to open an account.

IMPORTANT HSA INFORMATION

- Always ask your in-network doctor to file claims with your medical, dental, or vision carrier so you 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 at the financial institution of your choice, but only accounts opened through HSA Bank are eligible for automatic payroll deduction.

VIRTUAL VISITS

Your medical coverage offers telemedicine services through **UHC 24/7 Virtual Visits**. Connect anytime day or night with a board-certified doctor via your mobile device or computer for free or for the same or less cost than a visit to your regular physician. While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after-hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation, or away from home
- Are unable to see your primary care physician

WHEN TO USE TELEMEDICINE

Use telemedicine services for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold
- Flu
- Allergies
- Fever
- Urinary tract infections

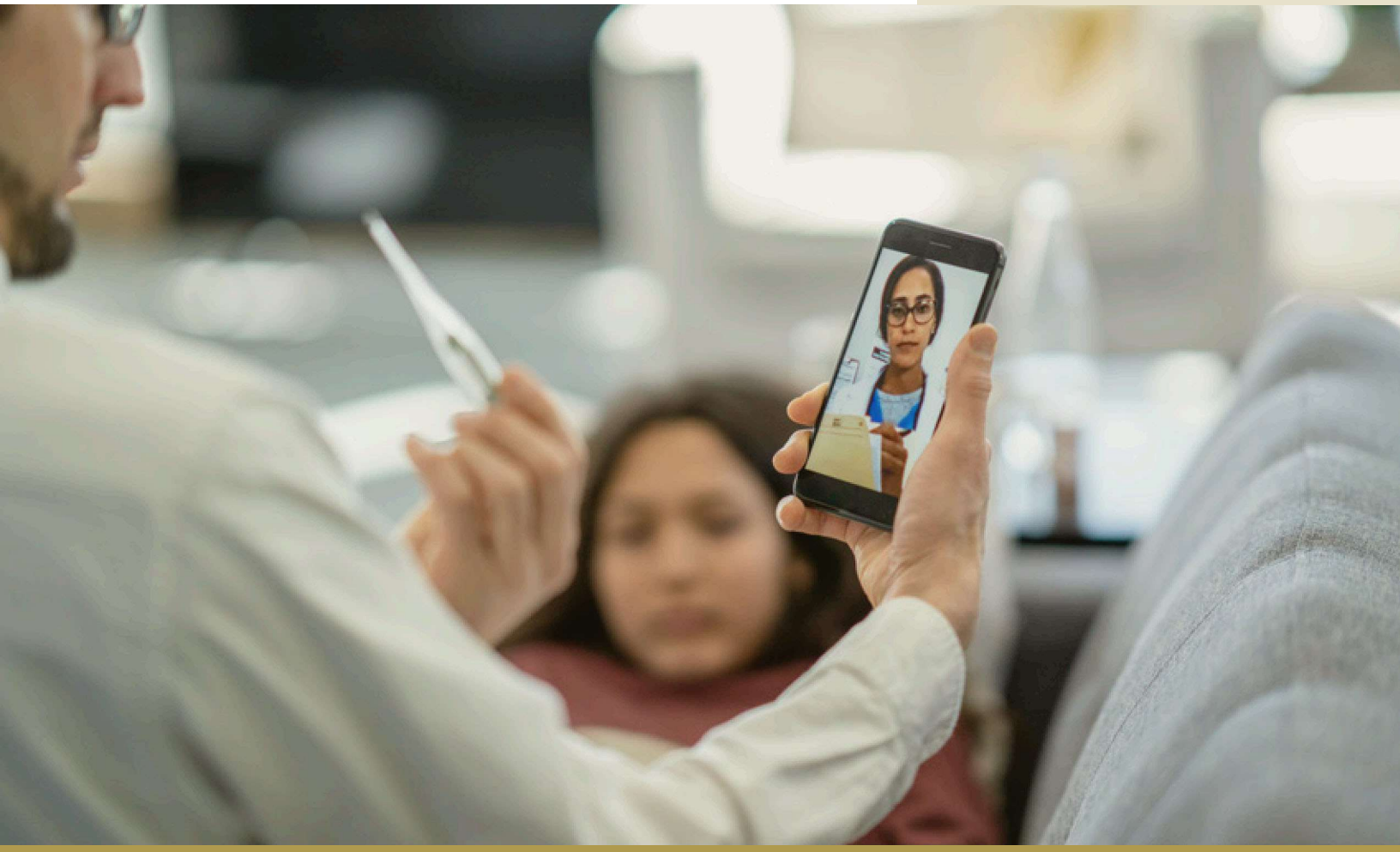
Do not use telemedicine for serious or life-threatening emergencies.

CREATE YOUR MDLIVE ACCOUNT

- Visit **www.myuhc.com/virtualvisits**
- Download the **UnitedHealthcare app**

KNOW YOUR TELEMEDICINE OPTIONS

Your regular provider may also offer telemedicine services, so it is best to ask now and know what your options are before you need care. They may offer telemedicine consultations by phone or video during or after normal office hours.



HEALTH CARE OPTIONS

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

HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
Non-Emergency Care				
 TELEMEDICINE	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	$$	15-30 minutes
Emergency Care				
 HOSPITAL ER	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	• Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones	$$$$	4+ hours
 FREESTANDING ER	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	• Most major injuries except trauma • Severe pain	$$$$$$	Minimal

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.

UHC RESOURCES

The following programs and services are available to you at no additional charge as a UHC member.

UHC Rewards

Earn up to **$300** with **UHC Rewards** for a variety of activities, including tracking your steps or sleep.

- Get a biometric screening $50
- Get an annual checkup $25
- Connect a tracker $25
- Take a health survey $15

Register for UHC Rewards

1. Download the **UnitedHealthcare app** or sign up at **www.myuhc.com**.
2. Select *UHC Rewards*.
3. Activate UHC Rewards.
4. Choose reward activities and start earning.

Get an Apple Watch with UHC Rewards

You can use your rewards – up to $300 – towards an Apple Watch. You can also choose the "Earn It Off" payment option, which has a $0 up-front cost. The remaining costs can be paid off as you earn your rewards points over 12 months.

Gym Discount

One Pass Select offers a low-cost nationwide gym membership – including digital fitness. Get access to gyms, studios, online workouts, and even grocery delivery with one monthly membership.

- There are no long-term contracts or annual gym registration fees.
- You can change your subscription or add family members (ages 18+) anytime.
- All tiers Classic or above come with grocery and home essentials delivery at no extra cost.

Membership Options*

	Digital	Classic	Standard	Premium	Elite
Monthly Fee	$10	$34	$69	$109	$159
Multi-location Access	-	Y	Y	Y	Y
Premium Network	-	-	Y	Y	Y

*An enrollment fee may apply.

EARN $50 FOR BIOMETRIC SCREENING

Learn your blood pressure, glucose, cholesterol, weight, and more to support your health and receive $50 with UHC Rewards. Get an at-home screening, complete the screening at one of many lab locations, or go to your doctor or clinic. Then, submit the completed screening form.

How to Get Started

1. Sign in on the UnitedHealthcare app.
2. Go to the Menu tab and select UHC Rewards.
3. Scroll to Available activities and select See all.
4. Select Biometric screening and then Get started.

Find a Gym Near You

Go to **www.onepassselect.com** to find a gym near you.

Gym partners include Anytime Fitness, Crunch, LA Fitness, Life Time, Orangetheory, and CrossFit.

Use your UHC Rewards dollars towards your One Pass Select subscription.

UHC RESOURCES

UHC MEMBER WEBSITE AND APP

Researching health information and keeping track of your family's health care benefits can be time-consuming. With the **UHC Member Portal** you can easily find the answers you are looking for, anytime day or night. You can also download the **UnitedHealthcare app** to have access to your member account.

- Find information on in-network doctors and other health care providers.
- Organize your medical claims online. View processed claims, remaining balances for deductibles, and out-of-pockets expenses.
- Check your current eligibility, deductibles, and out-of-pocket costs.
- Confirm what is covered and what is not covered.
- Learn about health conditions and treatment options.
- Request a medical ID card or print a temporary ID card.
- Update other coverage information for you and your eligible family members.

To create an account, log in at **www.myuhc.com**, click *Register Now*, and complete the required fields.

UHC CHRONIC CONDITION MANAGEMENT

Diabetes Support

With UHC's diabetes management, get a free blood sugar meter to help you monitor blood sugar levels. You and your doctor can choose from a variety of meters. For more details, call the phone number on your member ID card. Your free meter should arrive by mail within seven days of placing the order. The program also offers:

- The **UnitedHealthcare app** to track your progress
- Biometric sensors to monitor your health
- Strategies to help manage your diabetes
- Coaches to help answer your questions

Cancer Support Program

If you are preparing for cancer treatment or have already started, the Cancer Support Program connects you to the care you need and supports you and your family. Resources include:

- **An oncology nurse** to support you through your treatment journey
- **A personal advocate** to help you explore your options, answer questions, and manage symptoms and side effects
- **Access to highly rated physicians and providers**
- **Digital tools** for immediate and real-time guidance

To learn more, call an oncology nurse at **866-936-6002** or visit **www.myuhc.phs.com/cancerprograms**.

MATERNITY RESOURCES AND SUPPORT

Maternity Support offers online pregnancy resources and maternity support throughout your pregnancy and after giving birth. Using our various member tools and resources, you'll find help to learn what you need to know, including:

- What to expect during your pregnancy
- How to stay healthy before, during, and after your pregnancy
- Ways to manage your health through pregnancy and postpartum

Maternity Support is designed to work for all mothers, no matter what the pregnancy journey looks like.

To get started, go to **https://myuhc.phs.com/pregnancy-resources**.



DENTAL COVERAGE

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **MetLife**.

DPPO PLANS

Two levels of benefits are available with the DPPO plans: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

FIND A NETWORK PROVIDER

- Visit **www.metlife.com**
- Call **800-GET-MET8** (**800-438-6388**)

DENTAL BENEFITS SUMMARY

Refer to the MetLife Patient Charge schedule for full details.

	LOW PLAN		HIGH PLAN	
	In-Network	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150	$50 $150	$50 $150
Calendar Year Maximum Benefit Per individual	$1,000	$1,000	$1,500	$1,500
	You Pay		**You Pay**	
Preventive Care Exams, cleanings, complete series X-rays	$0	$0	$0	$0
Basic Services Endodontics, extractions, fillings, oral surgery, periodontics, root canals	20%[2]	20%[2]	$0[2]	$0[2]
Major Services Bridges, crowns, dentures, implants	50%[2]	50%[2]	40%[2]	40%[2]
Orthodontia • Children to age 26 and adults	50% $1,000 lifetime maximum	50% $1,000 lifetime maximum	50% $1,500 lifetime maximum	50% $1,500 lifetime maximum

[1]You will be reimbursed up to a Maximum Allowable Charge (MAC) for services received from an out-of-network dentist. You are responsible for charges in excess of the MAC.

[2]The amount you pay after the deductible has been met.



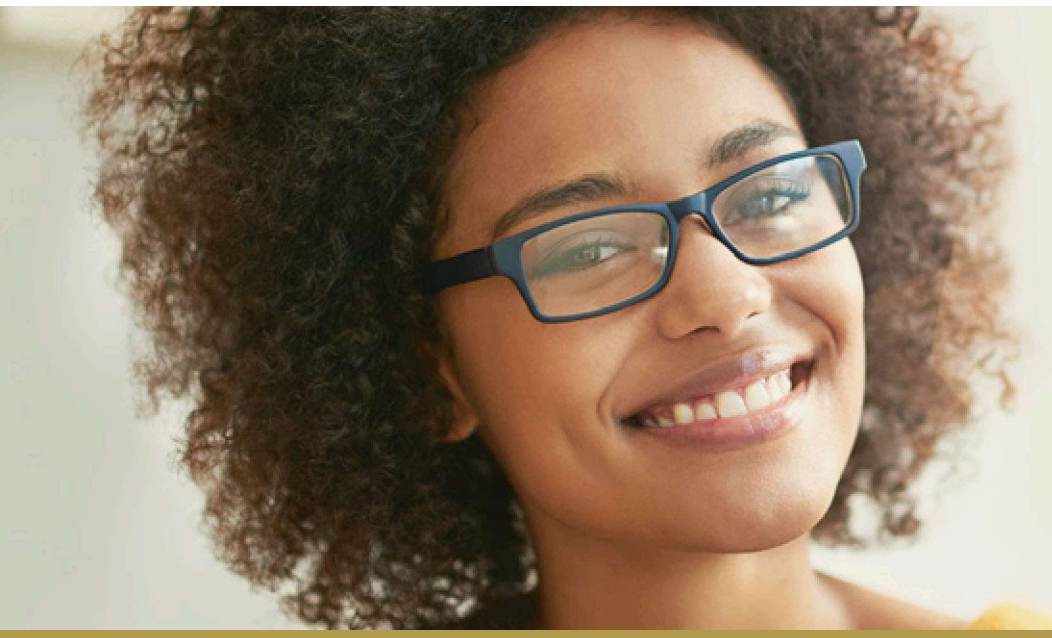
VISION COVERAGE

Our vision plans offer 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 plans will pay the highest level of benefits when you see an in-network provider. Coverage is provided through **MetLife**.

VISION BENEFITS SUMMARY

	LOW PLAN		HIGH PLAN	
	In-Network You Pay	**Out-of-Network Reimbursement[1]**	**In-Network You Pay**	**Out-of-Network Reimbursement**
Exam				
• Routine	$10 copay	Up to $45	$10 copay	Up to $45
• Retinal imaging	Up to $39 copay	Up to $45	Up to $39 copay	Up to $45
Lenses				
• Single	$25 copay	Up to $30	$10 copay	Up to $30
• Lined bifocal	$25 copay	Up to $50	$10 copay	Up to $50
• Lined trifocal	$25 copay	Up to $65	$10 copay	Up to $65
Frames				
• Retail	$25 copay plus balance over $100 allowance	Up to $55	$10 copay plus balance over $175 allowance	Up to $70
• Costco/Sam's Club/ Walmart	$25 copay plus 20% off balance over $55 allowance	N/A	$10 copay plus 20% off balance over $95 allowance	N/A
Contact Lenses In lieu of eyeglasses				
• Fitting and evaluation	$0	N/A	$0	N/A
• Elective	Balance over $100 allowance	Up to $80	Balance over $175 allowance	Up to $105
• Medically necessary	$25 copay	Up to $210	$10 copay	Up to $210
Benefit Frequency				
Exam	Once every 12 months		Once every 12 months	
Lenses	Once every 12 months		Once every 12 months	
Frames	Once every 24 months		Once every 12 months	
Contacts	Once every 12 months		Once every 12 months	

[1] If you choose an out-of-network provider, you will have increased out-of-pocket expenses, pay in full at time of service and file a claim for reimbursement.



FIND A NETWORK PROVIDER

- Visit **www.metlife.com/vision**
- Call **855-MET-EYE1 (638-3931)**

Visit **www.metlife.com/mybenefits** to download and submit a claim form for out-of-network reimbursement.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer three different FSAs: two for health care expenses and one for dependent care expenses. **Higginbotham** is our FSA administrator.

HEALTH CARE FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. You may contribute up to $3,400 annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in the HDHP medical plan and contribute to an HSA.

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, such as:

- Dental and orthodontia care (e.g., fillings, X-rays, and braces)
- Vision care (e.g., eyeglasses, contact lenses, and LASIK surgery)

DEPENDENT CARE FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full-time. You can use the account to pay for daycare or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

Things to Consider Regarding the Dependent Care FSA

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

How the Health Care and Limited Purpose FSAs Work

You can access the funds in your Health Care or Limited Purpose FSA two ways:

- Use your Higginbotham Benefits Debit Card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
  - **Fax – 866-419-3516**
  - **Email – flexclaims@higginbotham.net**
  - **Online – https://flexservices.higginbotham.net**

Higginbotham Benefits Debit Card

The Higginbotham Benefits Debit Card provides immediate access to funds in your Health Care or Limited Purpose Health Care FSA without needing to file a claim for reimbursement. If you use the debit card to pay anything other than a copay amount, you will need to submit an itemized receipt or an Explanation of Benefits (EOB). If you do not submit your receipts, you will receive a request for substantiation. You will have 60 days to submit your receipts after receiving the request for substantiation before your debit card is suspended. Check the expiration date on your card to see when you should order a replacement card(s).

FLEXIBLE SPENDING ACCOUNTS

HIGGINBOTHAM PORTAL

The **Higginbotham Portal** provides information and resources to help you manage your FSAs.

- Access plan documents, letters and notices, forms, account balances, contributions, and other plan information
- Update your personal information
- Look up qualified expenses
- Submit claims

Register on the Higginbotham Portal

Visit **https://flexservices.higginbotham.net** and click *Get Started*. Follow the instructions and scroll down to enter your information.

- Enter your Employee ID, which is your Social Security number with no dashes or spaces.
- Follow the prompts to navigate the site.
- If you have any questions or concerns, contact Higginbotham:
  - **Phone** – **866-419-3519**
  - **Email** – **flexclaims@higginbotham.net**
  - **Fax** – **866-419-3516**

Higginbotham Flex Mobile App

Easily access your Health Care or Limited Purpose Health Care FSA on your smartphone or tablet with the Higginbotham mobile app. Search for Higginbotham in your mobile device's app store and download as you would any other app.

- **View Accounts** – Includes detailed account and balance information
- **Card Activity** – Account information
- **SnapClaim** – File a claim and upload receipt photos directly from your smartphone
- **Manage Subscriptions** – Set up email notifications to keep up-to-date on all account and Health Care or Limited Purpose Health Care FSA debit card activity

Log in using the same username and password you use to log in to the Higginbotham Portal. **Note:** You must register on the Higginbotham Portal to use the mobile app.

IMPORTANT FSA RULES

- The maximum per plan year you can contribute to a Health Care or Limited Purpose Health Care 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 QLE.
- You can continue to file claims incurred during the plan year for another 90 days (up until March 31, 2027).
- Your Health Care or Limited Purpose Health Care 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 or Limited Purpose Health Care FSA into the next plan year. The carry-over rule does not apply to your Dependent Care FSA.

LIFE AND AD&D INSURANCE

Life and Accidental Death and Dismemberment (AD&D) insurance through **MetLife** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce by 50% at age 70.

BASIC LIFE AND AD&D

Basic Life and AD&D insurance are provided at no cost to you. You are automatically covered at $10,000 for each benefit.

VOLUNTARY LIFE AND AD&D

You may buy more Life and AD&D insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

VOLUNTARY LIFE AND AD&D	
Employee	• Increments of $10,000 up to five times annual earnings not to exceed $500,000 • Guaranteed issue $100,000
Spouse	• Increments of $5,000 up to $100,000 • Guaranteed issue $25,000
Child(ren)	• Flat amounts of $1,000, $2,000, $4,000, $5,000 or $10,000 • Guaranteed issue $10,000

Monthly Rates per $1,000			
Employee and Spouse[1]			
Age	**Rate**	**Age**	**Rate**
<30	$0.050	**50-54**	$0.250
30-34	$0.066	**55-59**	$0.389
35-39	$0.076	**60-64**	$0.574
40-44	$0.101	**65-69**	$1.067
45-49	$0.158	**70-99**	$1.731
Child(ren)			
To age 26		$0.294	

[1] Spouse rate is based on employee's age.

AD&D RATES	
Monthly Rates per $1,000	
Employee and Spouse	**Child(ren)**
$0.017	$0.054

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%).

Calculate Your Semimonthly Cost

Take the amount of coverage you want to purchase, divide by $1,000, then multiply by the age-appropriate rate listed in the table. **Example:** You are 42 years of age and would like to purchase $50,000 of coverage.

$50,000 ÷ $1,000 = 50 × $0.118 = $5.90 × 12 ÷ 24 = $2.95 per pay period cost

DISABILITY INSURANCE

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Short Term Disability (STD) and Long Term Disability (LTD) insurance for you to purchase through **MetLife**.

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	
Benefits Begin	15th day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	11 weeks
Pre-existing Condition Exclusion	12/12[1]

Monthly Rates per $10 of Coverage			
Age	**Rate**	**Age**	**Rate**
<45	$0.478	**55-59**	$0.642
45-49	$0.450	**60-64**	$0.698
50-54	$0.499	**65-69**	$0.692

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

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 Social Security Normal Retirement Age (SSNRA).

LONG TERM DISABILITY	
Benefits Begin	91st day
Percentage of Earnings You Receive	50%
Maximum Monthly Benefit	$4,000
Maximum Benefit Period	SSNRA
Pre-existing Condition Exclusion	6/12[1]

Monthly Rates per $100 of Coverage			
Age	**Rate**	**Age**	**Rate**
<35	$0.213	**50-54**	$0.589
35-39	$0.303	**55-59**	$0.795
40-44	$0.378	**60-64**	$0.786
45-49	$0.463	**65-69**	$0.700

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

CALCULATE YOUR SEMIMONTHLY COST

Short Term Disability

Take your weekly benefit, divide by 10, and multiply by the age-appropriate rate listed in the table to calculate the monthly rate, then divide by 24. For example, you are 40 years old and your weekly benefit is $500.

$500 ÷ 10 × $0.478 ÷ 24 = $1.00 per pay period cost

Long Term Disability

Take your monthly income, divide by 100, and multiply by the age-appropriate rate listed in the table to calculate the monthly rate, then divide by 24. For example, you are 47 years old and your monthly income is $4,000.

$4,000 ÷ 100 × $0.463 ÷ 24 = $0.77 per pay period cost

VOLUNTARY SUPPLEMENTAL INSURANCE

ACCIDENT INSURANCE

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan through **MetLife** helps offset the direct and indirect expenses resulting from an accident such as copayments, deductibles, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. See the plan document for full details.

ACCIDENT INSURANCE		
	Low Plan	**High Plan**
Ambulance—Ground/Air	$300/$1,000	$400/$1,250
Emergency Room	$150	$200
Hospital Admission	$1,000	$1,500
Hospital Confinement	$200 per day – up to 15 days	$300 per day – up to 15 days
Intensive Care Unit Admission	$1,000	$1,500
Intensive Care Unit	$200 per day – up to 15 days	$300 per day – up to 15 days
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$35-$10,000	$50-$15,000
Accidental Death and Dismemberment* • Employee • Spouse • Child(ren)	 $25,000 $12,500 $5,000	 $50,000 $25,000 $10,000

*Percentage of benefit paid for dismemberment is dependent on type of loss.

Monthly Accident Rates		
	Low Plan	**High Plan**
Employee Only	$8.67	$11.26
Employee + Spouse	$17.20	$22.24
Employee + Child(ren)	$20.59	$26.58
Employee + Family	$24.39	$31.47

HOSPITAL INDEMNITY INSURANCE

The Hospital Indemnity plan from **MetLife** helps you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay. Unlike traditional insurance that pays a benefit to the hospital or doctor, this plan pays you directly. It is up to you how you want to use the cash benefit. These costs may include meals, travel, childcare or eldercare, deductibles, coinsurance, medication, or time away from work. See the plan document for full details.

HOSPITAL INDEMNITY INSURANCE		
	Low Plan	**High Plan**
Hospital Admission	$500. Limited to 4 times per calendar year	$1,000. Limited to 4 times per calendar year
Hospital Confinement	$100 per day up to 31 days	$200 per day up to 31 days
ICU Admission	$500. Limited to 4 times per calendar year	$1,000. Limited to 4 times per calendar year
ICU Confinement	$100 per day up to 31 days	$200 per day up to 31 days
Monthly Hospital Indemnity Rates		
	Low Plan	**High Plan**
Employee Only	$8.67	$11.26
Employee + Spouse	$17.20	$22.24
Employee + Child(ren)	$20.59	$26.58
Employee + Family	$24.39	$31.47

VOLUNTARY SUPPLEMENTAL INSURANCE

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. See MetLife's plan document for full details.

CRITICAL ILLNESS INSURANCE	
Employee	$10,000, $20,000, or $30,000
Spouse	50% of Employee coverage amount
Children	50% of Employee coverage amount
First Occurrence Benefit	
Full Coverage Benign brain tumor, invasive cancer, coma, loss of speech, hearing or sight, paralysis, heart attack, kidney failure, major organ transplant, ALS, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, SLE, severe burn, stroke, childhood diseases	100% of benefit amount
Partial Coverage Skin cancer, autism spectrum disorder, non-invasive cancer, skin cancer, sudden cardiac arrest, transient ischemic attack, infectious diseases	5%-50% of benefit amount
Wellness Benefit One per covered person per calendar year	$50

Monthly Rates per $1,000 of Coverage*				
Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
<25	$0.43	$0.73	$0.72	$1.01
25 - 29	$0.48	$0.79	$0.76	$1.08
30 - 34	$0.55	$0.89	$0.83	$1.18
35 - 39	$0.71	$1.12	$0.99	$1.41
40 - 44	$0.92	$1.42	$1.20	$1.71
45 - 49	$1.19	$1.84	$1.48	$2.12
50 - 54	$1.51	$2.38	$1.79	$2.66
55 - 59	$1.96	$3.15	$2.25	$3.43
60 - 64	$2.48	$4.03	$2.76	$4.31
65 - 69	$3.09	$5.02	$3.38	$5.30
70 - 74	$4.02	$6.49	$4.30	$6.77
75+	$5.61	$8.87	$5.89	$9.15

*Multiply the rate shown above by the benefit amount divided by $1,000 (e.g., 15 for $15,000 of coverage) and round to two decimals to calculate rates for the quoted benefit amounts. Note that the per $1,000 rates are only applicable to the benefit amounts shown in this C&B. Final implemented rates may vary slightly due to rounding.

ADDITIONAL BENEFITS

The following programs and services are provided through **MetLife** at no additional cost to you.

WILLPREP

WillPrep services help you prepare a binding will at any time with the assistance of an attorney, or do it yourself via their online will preparation services website.

Covered services include:

- Preparing and updating wills, including complex will(s) and codicils, living wills, powers of attorney
- In-person or telephone consultations with an attorney
- Unlimited access to prepare or update a will

Visit **www.legalplans.com/estateplanning** to create an account and get started.

ESTATE RESOLUTION

This valuable service offers help in resolving an estate. A **MetLife Legal Plans** attorney will consult with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative burden upon your loved ones in their time of need. Services include:

- Unlimited, one-on-one consultations to talk to an attorney about authenticating an estate
- Prepared estate documents and in-court professional representation to help execute transfer of probate assets from the estate
- Help with correspondence and tax filing needed to transfer non-probate assets

Get Started

Call **800-821-6400** and speak to a client services representative, get a case number, and find an attorney. Help is available Monday through Friday, 8:00 a.m. – 8:00 p.m. EST.

FUNERAL DISCOUNT AND PLANNING SERVICES

To help ease the pain of loss, you have the opportunity to plan ahead for you or your loved ones. Funeral discounts and planning services are available at no additional cost to you.

- **Dignity Memorial** provides 24/7 access to compassionate counselors as well as discounts of up to 10% on funeral services through the largest network of funeral homes and cemetery providers in North America.
- **Bereavement Travel Services** can assist with time-sensitive travel arrangements to be with loved ones.

Contact Dignity Memorial today at **866-853-0954** or visit **www.finalwishesplanning.com** for details.

GRIEF COUNSELING

Grief counseling services are offered through **LifeWorks** to help you cope with a loss or a major life change. Professional counselors and services are ready to provide 24/7 confidential support that is tailored to fit your individual needs. Meet with a counselor in person or by phone. Get up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss such as death, bankruptcy, divorce, terminal illness, or losing a pet. To speak with a LifeWorks Counselor, call 866-454-2732 or visit **www.metlifebene.lifeworks.com** (user name: metlifebene, password: support).

PET INSURANCE

You may buy **MetLife** medical insurance for your pet(s) with after-tax payroll deductions.

The MetLife Pet Insurance plan covers cats, dogs, birds, and exotic animals. The plan offers a choice of reimbursement options (from 50% to 90%), so you can find coverage that best fits your budget, with deductibles from $0-$250 and levels of coverage from $500-unlimited.

See any veterinary professional for care and get discounts for multiple pets. Coverage includes:

- Accidents
- Illnesses
- Surgeries and hospitalization
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Therapeutic diets
- And more

Get 24/7 access to veterinary experts by phone, chat, and email, and unlimited help for general to urgent care needs, find nearby services, manage, records and more with the MetLife Pet app. Visit **www.metlifepetinsurance.com** for pre-existing condition exclusions.

TO ENROLL

You may enroll for pet coverage anytime during the year.

- Visit **www.metlife.com/getpetquote**
- Call **855-270-7387**



EMPLOYEE CONTRIBUTIONS

			Your Semimonthly Contributions
HEALTH SAVINGS ACCOUNT			
Individual	2026 maximum contribution: $4,300		$
Family	2026 maximum contribution: $8,750		$
DENTAL COVERAGE			
	Low Plan	**High Plan**	
Employee Only	$5.07	$8.09	$
Employee + Spouse	$10.15	$16.18	
Employee + Child(ren)	$13.71	$20.38	
Employee + Family	$20.76	$31.29	
VISION COVERAGE			
	Low Plan	**High Plan**	
Employee Only	$2.50	$4.44	$
Employee + Spouse	$5.01	$8.88	
Employee + Child(ren)	$4.24	$7.51	
Employee + Family	$6.99	$12.39	
FLEXIBLE SPENDING ACCOUNTS			
Health Care	2026 maximum contribution: $3,400		$
Limited Purpose	2026 maximum contribution: $3,400		$
Dependent Care	2026 maximum contribution: $7,500 (married filing jointly), $3,750 (married filing separately)		$
BASIC LIFE AND AD&D INSURANCE			
Employee Only	Paid by Donald L Mooney		$
VOLUNTARY LIFE AND AD&D INSURANCE			
Employee	See page 17 for rates		$
Spouse	See page 17 for rates		$
Child(ren)	See page 17 for rates		$
DISABILITY INSURANCE			
Short Term	See page 18 for rates		$
Long Term	See page 18 for rates		$
VOLUNTARY SUPPLEMENTAL BENEFITS			
Accident	See page 19 for rates		$
Hospital Indemnity	See page 19 for rates		$
Critical Illness	See page 20 for rates		$
Your Total 2026 Semimonthly Contributions			$

REQUIRED 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:

Donald L Mooney Enterprises
Human Resources
16302 Pleasantville Rd Suite 211
San Antonio TX 78233
866-722-9995

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 Donald L Mooney Enterprises 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. Donald L Mooney Enterprises has determined that the prescription drug coverage offered by the Donald L Mooney Enterprises 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. The HSA plan is not 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 Donald L Mooney Enterprises 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 Donald L Mooney Enterprises 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 **866-722-9995**.

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

REQUIRED NOTICES

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).

January 1, 2026
Donald L Mooney Enterprises
Human Resources
16302 Pleasantville Rd Suite 211
San Antonio TX 78233
866-722-9995

NOTICE OF HIPAA PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan – whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by Donald L Mooney Enterprises, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

Donald L Mooney Enterprises
Human Resources
16302 Pleasantville Rd Suite 211
San Antonio TX 78233
866-722-9995

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 July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: http://www.myalhipp.com/
Phone: 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

REQUIRED NOTICES

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

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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/health-care-coverage/
Phone: 1-800-657-3672

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

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
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

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

REQUIRED NOTICES

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 **July 31, 2025**, or for more information on special enrollment rights, 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 Donald L Mooney Enterprises group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Donald L Mooney Enterprises 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

Donald L Mooney Enterprises
Human Resources
16302 Pleasantville Rd Suite 211
San Antonio TX 78233
866-722-9995

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.



Higginbotham™



This brochure highlights the main features of the Donald L Mooney Enterprises 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. Donald L Mooney Enterprises reserves the right to change or discontinue its employee benefits plans anytime.