2026 Employee Benefits Guide

CONTENTS

Welcome to Your Benefits! 2
Eligibility 3
ALEX 4
Coverages and Responsibilities 5
Medical 6
Your Prescription Drug Benefits 8
Telemedicine 10
FSAs 11
HSA 12
Blue Access for Members℠ 13
Member Rewards 14
Cash in Lieu Program 15
Dental 16
Vision 17
Employee Contributions 18
Income Protection 19
Supplemental Medical 22
Planning for Retirement 23
Value Added Services 24
Norton Lifelock 25
Important Contacts 27
Required Notices 28

WELCOME TO YOUR BENEFITS!

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family, and be sure to act before the enrollment deadline.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 35 for more details.

ELIGIBILITY

If you work at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and 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

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. This applies to Medical, Dental, Vision, Health Care or Dependent Care Flexible Spending Accounts. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

QUALIFIED LIFE EVENT		DOCUMENTATION NEEDED
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

WHAT YOU NEED TO KNOW

- This year's Open Enrollment will be an active enrollment. This means you will need to go into Paycom to enroll or waive coverage for the 2026 Plan year.
- Open Enrollment will be from November 10th through November 21st.
- Elections and waivers will be due no later than November 21st.

WHAT'S NEW IN 2026

- We will continue to offer medical and dental coverage through BCBS. There are a few plan design updates for both the HDHP and PPO options. Employer contributions to the HSA will increase slightly for 2026.
- We are switching to UNUM for STD, LTD, Life and AD&D. Life insurance is the only plan that will remain the same if you don't make any changes during enrollment. If you'd like to adjust your coverage over the Guaranteed issue amount, you'll need to take action by submitting an Evidence of Insurability.
- Employee contributions for medical and dental coverage will increase slightly, while vision contributions the same for 2026.
- Please note there are 27 pay periods in 2026 (instead of 26). Benefit materials will reflect cost distribution over 27 pay periods.

ALEX

ALEX is an interactive online experience designed to help you make confident choices about your benefits during enrollment. Just answer a few questions about your preferences and health care needs, and ALEX can narrow it down to only show you plan options that give you the best coverage for the lowest cost.

FAST & FRIENDLY

Using ALEX is sort of like chatting with a smart, funny friend (who happens to have memorized all of your employer's plan documents). In less than 15 minutes, you'll create a plan of action you can use to speed through enrollment.

TOTALLY CONFIDENTIAL

ALEX is available to chat any time, day or night, at work or at home. Your responses are totally private and won't be shared with your employer, so you can explore freely.

SMARTER THAN EVER

ALEX has a new decision-making engine under the hood that harnesses the power of AI to analyze your responses and make sure suggested plans fit your risk tolerance and financial situtation.

COVERAGES AND RESPONSIBILITIES

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. Enstor shares the cost for your core benefits, and provides you the opportunity to participate in additional benefits where you pay the full cost.

BENEFIT	YOUR COST	TAX TREATMENT
Medical, Prescription	You share the cost	Pre-tax
Dental	You share the cost	Pre-tax
Vision	No cost to you	N/A
Health Savings Account	You share the cost	Pre-tax
Flexible Spending Accounts	You pay 100%	Pre-tax
Basic Life / AD&D	No cost to you	N/A
Voluntary Life & AD&D	You pay 100%	After-tax
Disability Coverage (STD & LTD)	No cost to you	N/A
401(k) Retirement Savings Plan	You share the cost	Pre-tax or After-tax
Employee Assistance Plan	No cost to you	N/A
Additional Voluntary Benefits	You pay 100%	After-tax

Pre-tax means the cost comes out of your pay before taxes are deducted. After-tax means the cost comes out of your pay after taxes are deducted.

MEDICAL

BlueCross BlueShield of Texas

Medical insurance is essential to your well-being, and our Medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens. The Medical plans are provided through BCBSTX.

You will have access to BCBS providers in any state that you live in.

PARTS OF YOUR MEDICAL PLAN

- **Preventive care** – always 100% covered when you use in-network providers and includes things like physical exams, flu shots and screenings.
- **Annual deductible amounts** – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Annual out-of-pocket maximums** – the most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered in-network medical care for the remainder of the year.
- **Copays** – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum. Copays only apply to the PPO (not HDHP PPO).
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance.

PREVENTIVE SCREENING	DETAILS
Physical Exams/Health Guidance	Every 1 - 2 years for ages 19 - 49, and every year for age 50+
Blood Pressure	Every 2 years for age 40+
Colorectal Cancer Screening	Starting at age 50, or earlier if recommended by your doctor
Fasting Blood Glucose Screening	Every 3 years, starting at age 45 for high-risk individuals
Lipid Panel	Every 5 years starting at age 20, or more frequently for those at high risk
Prostate Screening (for Men)	Age 55+
Mammogram (for Women)	Starting at age 40, and annually as recommended
Pap Test for Women Age 21 to 65	Every 3 years, or annually as recommended
Preventive Medications	With a prescription, some preventive medications, such as aspirin, folic acid, tobacco cessation medications, Vitamin D, iron and oral fluoride are covered

MEDICAL PLAN COMPARISON

BlueCross BlueShield of Texas

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

	BLUE CHOICE PPO WITH HSA		BLUE CHOICE PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	YOU PAY			
CALENDAR YEAR DEDUCTIBLE				
Individual	$3,500	$7,000	$1,500	$3,000
Family	$7,000	$14,000	$4,500	$9,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)				
Individual	$5,000	Unlimited	$6,000	Unlimited
Family	$10,000		$18,000	
COINSURANCE / COPAYS				
Preventive Care	$0	40%*	$0	40%*
Primary Care Physician	20%*	40%*	$40 copay	40%*
Specialist	20%*	40%*	$80 copay	40%*
Urgent Care	20%*	40%*	$75 copay	40%*
Emergency Room	20%*		$500 copay; then 20% (waived if admitted)	
Diagnostic Test (X-ray, blood work)	20%*	40%*	20%*	40%*
Imaging (CT/PET scans, MRIs)	20%*	40%*	20%*	40%*
RETAIL RX (UP TO 30-DAY SUPPLY)				
Generic	10%*	20%* + 50%	$0 copay	$10 + 50%
Generic Non-Preferred	10%*	20%* + 50%	$10 copay	$20 + 50%
Brand Preferred	20%*	30%* + 50%	$50 copay	$70 + 50%
Brand Non-Preferred	30%*	40%* + 50%	$100 copay	$120 + 50%
Specialty Preferred	40%*	40%* + 50%	$150 copay	$150 + 50%
Specialty Non-Preferred	50%*	50%* + 50%	$250 copay	$250 + 50%
MAIL ORDER RX (UP TO 90-DAY SUPPLY)				
Generic	30%*	Not covered	$0 copay	Not covered
Generic Non-Preferred	60%*		$30 copay	
Brand Preferred	60%*		$150 copay	
Brand Non-Preferred	120%*		$300 copay	

* After deductible

YOUR PRESCRIPTION DRUG BENEFITS

Through your group health plan, you have the following prescription drug benefit offerings through Blue Cross and Blue Shield of Texas (BCBSTX).

PREFERRED PHARMACY NETWORK

Where you fill your prescription matters. You can save money by using an in-network pharmacy as part of your prescription drug benefit plan. When you fill a prescription for up to a 30-day supply of a covered prescription drug from a retail pharmacy that contracts to participate in the Preferred Pharmacy Network, you may pay the lowest copay or coinsurance amount. If you fill a prescription at a non-preferred, in-network pharmacy, you may pay a higher copay or coinsurance.

You can also fill a prescription for up to a 90-day supply of a covered prescription drug at an in-network preferred retail pharmacy.

To find a preferred pharmacy in the network, sign in to **myprime.com**. Please note that changes may be made to the participating pharmacies in the future.

PERFORMANCE ANNUAL DRUG LIST

Your benefit plan is based on the Performance Annual Drug List. All covered drugs are shown on the list, unless you have a benefit exclusion. Drugs that are not shown are not covered. Most major drug classes are covered on the drug list. The Performance Annual Drug List is updated online quarterly.

On an annual basis, some drugs may move to a higher payment tier and some drugs may no longer be covered under the prescription drug benefit. As a reminder, drugs that have not received U.S. Food and Drug Administration (FDA) approval are not covered for safety reasons.

For drugs that move to a higher tier, they may still be eligible for coverage, but you may have to pay a higher copay or coinsurance amount. For drugs that are no longer covered, a covered generic or lower cost alternative drug may be right for you. Depending on your prescription drug benefit, these alternative drugs may cost you less.

If you are taking or are prescribed a drug that is changed, ask your doctor about your drug therapy options. These drugs may cost you less. Your doctor can also request a drug list coverage exception from BCBSTX (unless you have a benefit exclusion). As always, treatment decisions are between you and your doctor.

Visit **bcbstx.com** for a full and up-to-date list.

For more information about prescription drug benefits, you can visit **https://www.bcbstx.com/rx-drugs/pharmacy-and-prescription-plans/pharmacy-prescription-plan-information**, log in to Blue Access for Members℠ (BAM) and click on the 'Prescription Drugs' link or call the number on your member ID card.

UTILIZATION MANAGEMENT PROGRAMS

Your prescription drug benefit plan has Prior Authorization, Step Therapy and Dispensing Limit programs. These programs are updated on an annual basis and promote safe and proper use of medicines. Please note: Select drugs that are new to the market may also need prior authorization.

- **Prior Authorization (PA)** – If your drug is part of the PA program, you will need to have your doctor submit pre-approval (also known as a prior authorization request).
  - If your request is approved, you will pay for your share of the drug, based on your benefit plan.
  - If your request is not approved, the drug will not be covered. You may still fill the prescription, but you may have to pay for the full amount charged by the pharmacy.
- **Step Therapy (ST)** – If your drug is part of the ST program, you may need to use a generic or lower-cost preferred drug first before coverage can be approved for another drug. If you and your doctor decide that the preferred drug is not right for you, your doctor can submit a step therapy exception request.
  - Members who are now taking a drug included in the program may not be affected.
- **Dispensing Limits** – Some drugs may have limits on them, such as how much medicine can be covered per prescription or in a given time span. These coverage limits make sure that medication use is as intended by the FDA. Members taking or prescribed a drug that has a dispensing limit may not get coverage for an amount above the limit. If you and your doctor decide that the dispensing limit may not be right for you, your doctor can submit a request.

Call the number listed on your member ID card for questions about a certain drug, or visit **bcbstx.com/rx-drugs/pharmacy/pharmacy-programs** for a list of prior authorization and step therapy programs. For information about dispensing limits, visit **bcbstx.com/rx-drugs/drug-lists/drug-limits**.

Remember: Choice of pharmacy and treatment decisions are always between you and your doctor, and cost is only one factor. Only you and your doctor can decide which medicine is right for you. Talk with your doctor or pharmacist about any questions or concerns you have about medicines you are prescribed.

Coverage is always subject to the terms and limits of your benefit plan. Some drugs may call for members to meet certain criteria before prescription drug benefit coverage may be approved. See your plan materials for details.

TELEMEDICINE

MDLIVE
BlueCross BlueShield of Texas

When you need care — anytime, day or night — or when your primary care provider is not available, telemedicine can be a convenient option. With MDLIVE, you don't have to drive to the doctor's office or sit in a waiting room when you're sick — you can see your doctor from the comfort of your own bed or sofa.

REGISTER TODAY FOR MDLIVE SO YOU ARE READY WHEN YOU NEED CARE

Avoid germs in the ER, urgent care clinic or doctor's office.

See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends and holidays.

Get treated for more than 80 common conditions including colds, flu, allergies and more.

Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby in less time than your usual doctor visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

USING TELEMEDICINE IS AS EASY AS ONE, TWO, THREE

STEP 1

REGISTER NOW

Setting up your secure account takes only minutes.

- Call 888-680-8646
- Go to **MDLIVE.com/bcbstx**
- Text **BCBSTX** to 635-483
- Download the app

STEP 2

REQUEST A VISIT

You can have a doctor visit right away or schedule an appointment — all by phone, computer or the app.

STEP 3

FEEL BETTER

Get treated by one of our doctors who can prescribe medication if necessary.

- PPO copay is $0 and HSA is $48*

** Behavioral Health virtual visits will be subject to different fees.*

FSAS

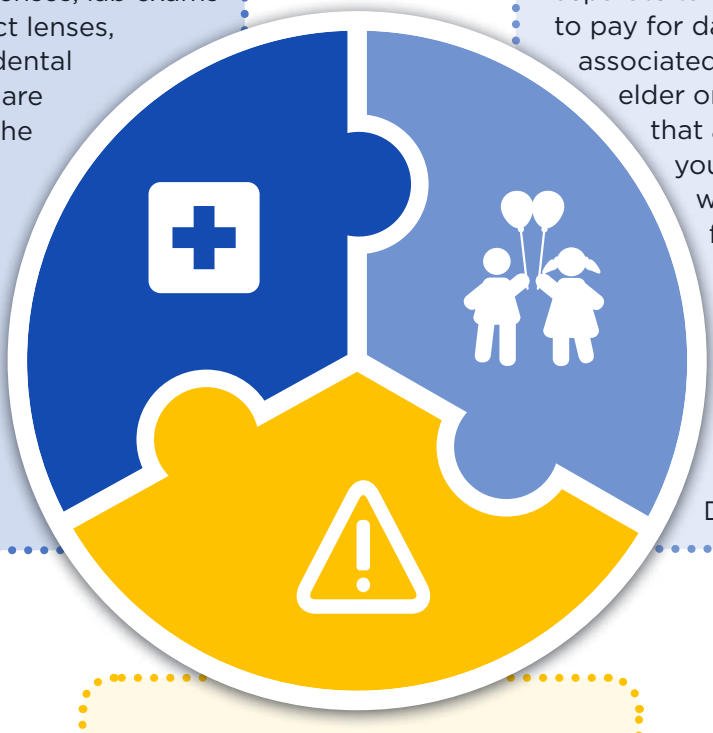
Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses using tax-free dollars. Important: There is a “use it or lose it” rule imposed by the IRS. The FSA is now administered through HSA Bank.

HEALTH CARE FSA

Contribute up to $3,400 per year, pretax, to pay for copays, prescription expenses, lab exams and tests, contact lenses, eyeglasses and dental expenses. If you are a participant in the HSA you are not eligible for FSA.

DEPENDENT CARE FSA

Contribute up to $7,500 per year ($3,750 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses. You can be enrolled in either plan and make contributions to the Dependent Care FSA.



USE IT OR LOSE IT

You have until March 31st of the following calendar year to file for expenses incurred from January 1st - December 31st of the plan year. Any unused dollars will be forfeited per IRS regulations for pretax contributions

HSA

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP Medical plan.

HOW A HEALTH SAVINGS ACCOUNT WORKS

ELIGIBILITY

You must be enrolled in the High Deductible Health Plan (HDHP.)

CONTRIBUTIONS

The Company contributes: $850 (Employee Only), or $1,500 (Employee Plus Spouse/Children/Full Family).

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the IRS maximum of $4,400 if you enroll only yourself or $8,750 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are age 55 or older. The annual HSA contribution limit will include any contributions made by Enstor.

ELIGIBLE EXPENSES

You may use your HSA funds to cover medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

USING YOUR ACCOUNT

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

YOUR HSA IS ALWAYS YOURS — NO MATTER WHAT.

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

BLUE ACCESS FOR MEMBERS℠

BlueCross BlueShield of Texas

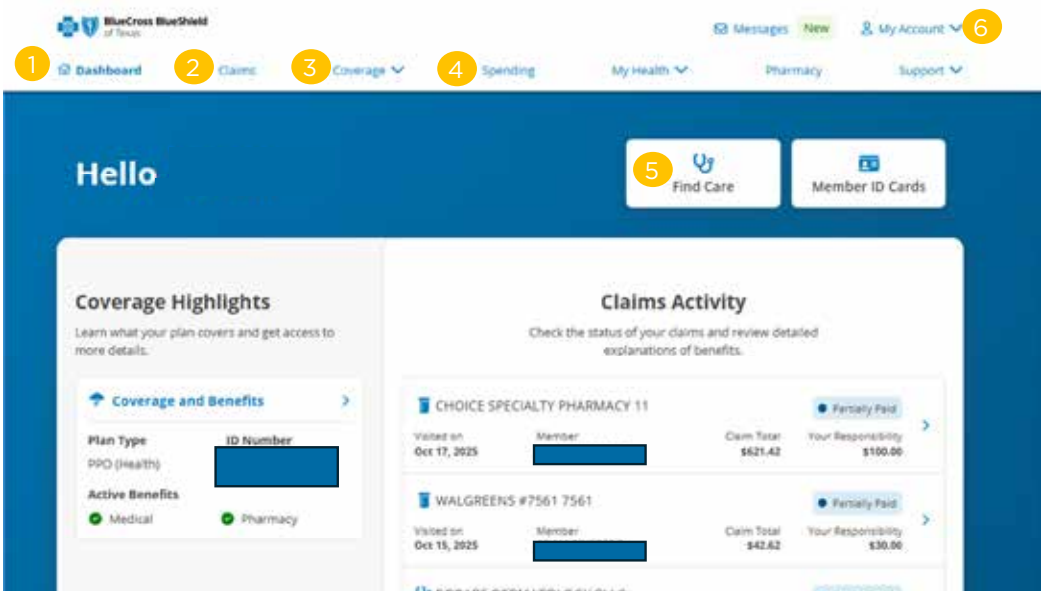
YOUR HEALTH AT YOUR FINGERTIPS

Get information about the cost of procedures, find a doctor or request an ID card. You can do it all – simply and securely – on Blue Access for Members℠ (BAM). With BAM, you can:

- Find in-network doctors and hospitals.
- View your digital member ID, or order new or replacement IDs.
- Review your benefits and dependent coverage.
- Covered dependents age 18 and over can have their own BAM accounts.

LET'S GET STARTED

1. Go to **bcbstx.com**.
2. Click **Register Here**.
3. Use the information on your member ID card to complete the registration process.



1. **Dashboard** – See your family's claims and health care spending at a glance, order an ID, navigate the site quickly and easily.
2. **Claims** – View quick claims summaries or download your Explanation of Benefits (EOB).
3. **Coverage** – See benefit highlights for your medical, dental and pharmacy plans.
4. **Spending** – Keep track of your deductible and out-of-pocket expenses.
5. **Find Care** – Find in-network doctors, hospitals and other health care providers quickly and easily.
6. **My Account** – Use this menu for everything else: View your health history, update your profile and preferences, sign up for electronic EOBs, find claim forms, manage privacy preferences and contact us.

MEMBER REWARDS

BlueCross BlueShield of Texas

REWARD EMPLOYEES AND REALIZE BIG SAVINGS

Member Rewards[1] is a comprehensive engagement and rewards program offered by Blue Cross and Blue Shield of Texas (BCBSTX). It is administered by Sapphire Digital and guides members to cost-effective options, helping achieve measurable savings for both employers and employees.

The Member Rewards program offers a cash reward to members when they shop for procedures or services, and select a low-cost, reward-eligible option. It uses the Provider Finder® tool, which helps members:

- Compare costs and quality
- Estimate out-of-pocket costs
- Assist in making treatment decisions with their doctors

Member Rewards offers an average savings of $527 per claim.[2]

HOW DOES IT WORK?

1. The member searches online via Provider Finder to find a reward-eligible location for a procedure or service.
2. The member gets the procedure or service at their chosen reward-eligible location.
3. The member receives a cash reward by check, which will be mailed directly to their home, after the claim is paid and the location is verified as reward-eligible.

GET STARTED TODAY!

Call your BCBSTX Account Representative for more information about how Member Rewards can help your employees become smarter shoppers, earn rewards and lower their – and your – health care costs.

[1] Sapphire Digital is an independent company that has contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to administer the Member Rewards program for members with coverage through BCBSTX. Reward-eligible options and reward amounts are subject to change. Eligibility for rewards is subject to terms and conditions of the Member Rewards program. Amounts received through Member Rewards may be taxable. BCBSTX does not provide tax advice. Members that have primary coverage with Medicaid or Medicare are not eligible to receive incentive rewards under the Member Rewards program. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them."

[2] The average savings figure is based on Sapphire Digital data from January through December 2021 for medical services only. Estimates found on Provider Finder are estimates for various providers, facilities and procedures. Savings and reward amounts depend on the options members choose.

CASH IN LIEU PROGRAM

Employees who decide to opt out of the Enstor Medical Plan must be active and benefit eligible in order to receive the Cash in Lieu payment. The employee must provide annual documentation that they and their tax family members have obtained MEC (Minimum Essential Coverage) through another employer group plan (spouse or parent) but not coverage obtained in the individual market, Exchange or Marketplace, or Medicare or Medicaid. These employees will be required to complete the Cash in Lieu form each year (form available through HR).

- **Employee Only:** $2,500 total cash payment
- **Employee + Spouse OR Employee + One Child:** $3,500 total cash payment
- **Employee + Family:** $5,000 total cash payment

PAYMENT STRUCTURE

Employee will receive 2 equal payments as follows:

- 1st Payment on the last pay day of January 2026
- 2nd Payment on the last pay day of July 2026
- Prorated for new hires

Employees who opt out of the Enstor Medical plan are still able to enroll in the Dental plan.

Enstor will continue to pay 100% of the Vision, Life, Short-Term Disability and Long-Term Disability plans.

DENTAL

BlueCross BlueShield of Texas

Taking care of your oral health is not a luxury — it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the Blue Cross/Blue Shield network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

	BCBS DENTAL PPO PLAN
	In-Network
CALENDAR YEAR PLAN MAXIMUM	
Per Individual	$1,500 annual max
	YOU PAY
CALENDAR YEAR DEDUCTIBLE	
Individual	$50
Family	$150
PREVENTIVE CARE	
Exams, Cleanings, X-rays	$0
BASIC SERVICES	
Fillings, Extractions, Root Canal, Repair of Dentures	20%
MAJOR PROCEDURES	
Crowns, Core Buildup, Implants, Installation of Dentures	50%
ORTHODONTIA	
Children (up to 19th birthday)	50% up to a lifetime maximum benefit of $1,500 per individual; deductible waived

(For a complete listing of covered benefits refer to your plan documents.)

VISION

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive Vision coverage. You do not have to be enrolled in Medical coverage to elect Vision coverage or cover the same dependents under Medical and Vision.

The table below summarizes the key features of the VSP Vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
Wellvision Exam	▪ Focuses on your eyes and overall wellness	$10	Every 12 months
Essential Medical Eye Care	▪ Retinal screening for members with diabetes ▪ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. ▪ Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
Frame*	▪ $150 featured frame brands allowance ▪ $150 frame allowance ▪ 20% savings on the amount over your allowance ▪ $130 Walmart®/Sam's Club® frame allowance ▪ $70 Costco® frame allowance	Included in Prescription Glasses	Every 12 months
Lenses	▪ Single vision, lined bifocal, and lined trifocal lenses ▪ Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	▪ Standard progressive lenses ▪ Premium progressive lenses ▪ Custom progressive lenses ▪ Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
Contacts (Instead of Glasses)	▪ $150 allowance for contacts; copay does not apply ▪ Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** ▪ Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. ▪ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VS provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening ▪ No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction ▪ Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
YOUR COVERAGE GOES FURTHER IN-NETWORK			
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.			

EMPLOYEE CONTRIBUTIONS

MEDICAL

	BCBS PPO			
	FUNDING RATES	ER CONTRIBUTION	EE CONTRIBUTION	BI-WEEKLY
Employee	$1,027.54	$918.18	$109.36	$48.60
Employee + Spouse	$2,177.66	$1,958.96	$218.70	$97.20
Employee + Child(ren)	$1,942.55	$1,739.46	$203.09	$90.26
Employee + Family	$3,092.89	$2,769.29	$323.60	$143.82

	BCBS HDHP WITH HSA			
	FUNDING RATE	ER CONTRIBUTION	EE CONTRIBUTION	BI-WEEKLY
Employee	$845.62	$777.11	$68.51	$30.45
Employee + Spouse	$1,792.12	$1,652.89	$139.23	$61.88
Employee + Child(ren)	$1,598.65	$1,459.42	$139.23	$61.88
Employee + Family	$2,545.32	$2,337.58	$207.74	$92.33

DENTAL PPO

	MONTHLY RATE	ER CONTRIBUTION	EE CONTRIBUTION	BI-WEEKLY
Employee	$33.28	$22.12	$11.16	$4.96
Employee + Spouse	$66.56	$43.00	$23.56	$10.47
Employee + Child(ren)	$89.93	$64.03	$25.90	$11.51
Employee + Family	$135.91	$94.89	$41.01	$18.23

VISION

	MONTHLY RATE	ER CONTRIBUTION	EE CONTRIBUTION	BI-WEEKLY
Employee	$8.25	$8.25	$0.00	$0.00
Employee + Spouse	$13.20	$13.20	$0.00	$0.00
Employee + Child(ren)	$13.47	$13.47	$0.00	$0.00
Employee + Family	$21.72	$21.72	$0.00	$0.00

INCOME PROTECTION

LIFE AND AD&D

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death or in the case of a covered accidental injury. Basic Life is provided for you at no cost, and you have the option to purchase coverage for your dependents.

BASIC LIFE AND AD&D

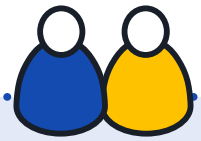
FOR YOU

1x your basic annual earnings, to a maximum of $300,000 rounded up to the nearest $1,000

VOLUNTARY LIFE

FOR YOU

Increments of $10,000 1x to 5x your annual base salary up to $500,000 rounded up to the next $1,000. Guaranteed Issue amount of $100,000. Any amount over the guaranteed issue amount will require EOI.



FOR YOUR SPOUSE

Increments of $10,000 up to the lesser of 50% of your coverage or $250,000. Guaranteed Issue amount of $10,000. Any amount over the guaranteed issue amount will require EOI.

FOR YOUR CHILD

Live Birth to 6months: $1,000

6 months to 26 years: $10,000

Increments of $1,000

VOLUNTARY AD&D

You may elect Voluntary AD&D coverage in increments of $10,000 up to the lesser of 10x your annual base salary or $500,000.

Voluntary Family AD&D coverage is also available. The amount of Voluntary Family AD&D for your dependents is equal to a percentage of your AD&D coverage:

- 50% for spouse if no children
- 40% for spouse if eligible children
- 10% for children if eligible spouse
- 15% for children if no spouse

Please make sure to update your beneficiary information in Paycom.

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Voluntary Life and Voluntary AD&D are not a part of the active enrollment and any changes or enrollments need to be sent to **hr@enstorinc.com**.

VOLUNTARY LIFE RATES

	MONTHLY	BI-WEEKLY
Under age 25	$0.060	$0.027
25-29	$0.060	$0.027
30-34	$0.080	$0.036
35-39	$0.100	$0.044
40-44	$0.160	$0.071
45-49	$0.250	$0.111
50-54	$0.400	$0.178
55-59	$0.630	$0.280
60-64	$0.840	$0.373
65-69	$1.600	$0.711
70-74	$2.810	$1.249
75-99	$8.690	$3.862

Child Rate: $0.500 Monthly; $0.222 Bi-Weekly

VOLUNTARY AD&D RATES

COVERAGE	MONTHLY	BI-WEEKLY
Employee Only	$0.035	$0.016
Spouse & Child	$0.035	$0.016

*To find your monthly rate for Life and AD&D, please use the calculation below. See plan policies for specific plan details including benefit reduction schedules.

CALCULATING YOUR COST

Choose the amount of coverage you want.

_____ Line 1

Divide the amount in Line 1 by $1,000.

_____ Line 2

Use the chart above to find the cost for your age and enter it on Line 3.

_____ Line 3

Multiply the amount in Line 2 by the amount in Line 3 to find your monthly cost.

_____ Line 4

DISABILITY INSURANCE

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience. Disability benefits are administered by UNUM and provided by Enstor.

DISABILITY BENEFITS AT A GLANCE

FIRST 7 DAYS
(ELIMINATION PERIOD)

PTO replaces 100% of your pay until STD begins.

SHORT TERM DISABILITY

Approved STD replaces 100% of your pre-disability earnings for 2 weeks. Then the benefit reduces to 60% to a weekly maximum of $2,500 after 2 weeks.

Benefit begins after elimination period and disability has been approved by UNUM.

LONG TERM DISABILITY

LTD replaces 60% of your pre-disability earnings to a $10,000 monthly maximum.

Benefit begins after 26 weeks of disability, and the benefit duration is based on the employee's age when the benefit commences. LTD is paid directly from UNUM.

SUPPLEMENTAL MEDICAL

Supplemental Medical plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary and employee paid.

ACCIDENT INSURANCE

Accident insurance pays out a lump sum directly to you if you become injured from an accident. Qualifying injuries include a broken limb, loss of a limb, burns, lacerations or paralysis. You may use the funds any way you choose—such as out-of-pocket medical expenses, transportation, and lodging. Coverage is available for you, your spouse and eligible dependent children, and you do not need to answer medical questions to receive coverage. There are two Accident plans to choose from with UNUM. Employee's cost is based on plan choice and tier.

CRITICAL ILLNESS

If you suffer from a serious illness, such as cancer, stroke or a heart attack, medical insurance may not provide all the coverage you need. Critical Illness insurance can ease the financial strain and help you focus on your recovery. Upon diagnosis of a covered illness, you'll receive a lump-sum benefit to cover your deductible, coinsurance, living expenses, mortgage or rent, or other expenses you may have. Employee's cost is based on plan choice and age.

	BENEFIT AMOUNT	GUARANTEED ISSUE AMOUNT
Employee	$10,000, $20,000	Up to $20,000
Spouse	50% of employee amount	Up to $10,000
Children	50% of employee amount, including childhood conditions	Up to $10,000

HOSPITAL INDEMNITY

Hospital expenses can add up quickly, even with medical coverage. With Hospital Indemnity insurance, you will receive a cash benefit if you or a covered family member has a hospital stay. You may use the money to pay for out-of-pocket medical expenses. Employee's cost is based on age and tier.

HOSPITALIZATION BENEFITS	PLAN
Admission (1 day per year)	$1,000
Admission – Hospital ICU (1 day per year) (additive to Admission)	$1,000
Daily Stay (per day up to 31 days)	$100
Daily Stay – Hospital ICU (per day up to 30 days) (additive to Daily Stay)	$100
Short Stay (1 day per year)	$250

PLANNING FOR RETIREMENT

What does retirement look like for you? Maybe you plan to travel the world or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan allows you to save for retirement on a pretax basis. Once you are eligible, you will be auto enrolled with a 5% contribution through payroll deductions. You can make changes to your contribution amount through the Empower website.

INCREASE YOUR RETIREMENT SAVINGS WITH A 401(k)

- The Company will match your contribution for each dollar you contribute to the plan, up to the first 5%.
- The 2026 401(k) contribution limit has not been released by the IRS. We will update you once this has been released.
- Change the amount of your contributions or stop your payroll contributions at any time on Empower's website.
- Decide how to invest your 401(k) or allow the plan to choose for you.
- Age 50 or older? Make an additional "catch-up" contribution of up to $7,500 to save even more.

To learn more about your retirement account, call Empower at 800-338-4015 or visit **https://participant.empower-retirement.com/participant/#login**.

It is important to designate or update your beneficiary in Empower.

VALUE ADDED SERVICES

Your Unum coverage goes beyond traditional insurance. You also have access to programs that support your overall well-being — at work, at home, and wherever life takes you. These services provide everyday support for personal challenges, travel emergencies, health goals, and financial or legal concerns. Each program is included as part of your Unum coverage and is designed to help you and your family feel more confident, connected, and cared for year-round.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Confidential help is available anytime, day or night, for life's challenges — big or small. Unum's EAP connects you and your household members with licensed professional counselors who can assist with stress, anxiety, relationship issues, grief, work conflicts and more. You also have access to specialists for family and life needs such as child care, elder care, financial coaching, debt management and legal questions. This program includes 24/7 access, up to three in-person or virtual sessions at no cost, and secure, confidential support for short-term issues and referrals for additional care.

Employee Assistance Program – Work/Life Balance
Toll-free 24/7 access: 1-800-854-1446, **www.unum.com/lifebalance**

TRAVEL ASSISTANCE

When traveling 100 miles or more from home — for business or vacation — Unum's worldwide emergency travel assistance can help you locate hospitals, replace prescriptions or arrange emergency medical evacuation. You can also access interpreter services, passport replacement and other travel-related resources. Coverage extends to you and your eligible dependents and is available anywhere in the world, 24 hours a day.

Download and activate the Assist America Travel App today from the Apple® App Store or Google Play™.
Reference Number: 01-AA-UN-762490

BE WELL BENEFIT

With Unum's Be Well Benefit, you and your covered family members can receive a cash incentive for completing eligible annual health screenings such as physical exams, well-child visits, immunizations and preventive cancer or cardiovascular screenings. Many of these tests are routine, making it easy to take advantage of this benefit while supporting your overall well-being.

File your claim online with a one-time registration on **unum.com**, by mail or over the phone.
Simply call 1-800-635-5597 to learn more.

LIFE PLANNING, FINANCIAL & LEGAL RESOURCES

If you or a loved one faces a terminal illness or loss, Unum offers compassionate guidance through certified consultants who provide financial and legal assistance at no additional cost. You can receive support with estate settlement, taxes, Social Security, insurance benefits and other important decisions — all confidential and included with your Unum group life coverage.

Assistance is only a call or click away to speak with a Life Planning Consultant, you can call: 1-800-422-5142 (multilingual) or visit **healthadvocate.com/unumlifeplanning**

NORTON LIFELOCK

CONGRATULATIONS ON TAKING THE FIRST STEP TOWARD A SAFER DIGITAL LIFE.

To ensure that your identity, devices and privacy have the protection they need, please activate your membership.

ACTIVATE YOUR MEMBERSHIP IN 3 EASY STEPS.

STEP 1
Verify your identity and create login credentials at **norton.com/ebsetup**.

STEP 2
Activate your plan features on your dashboard.

STEP 3
Download the Norton 360 and LifeLock Identity apps to receive alerts on-the-go.

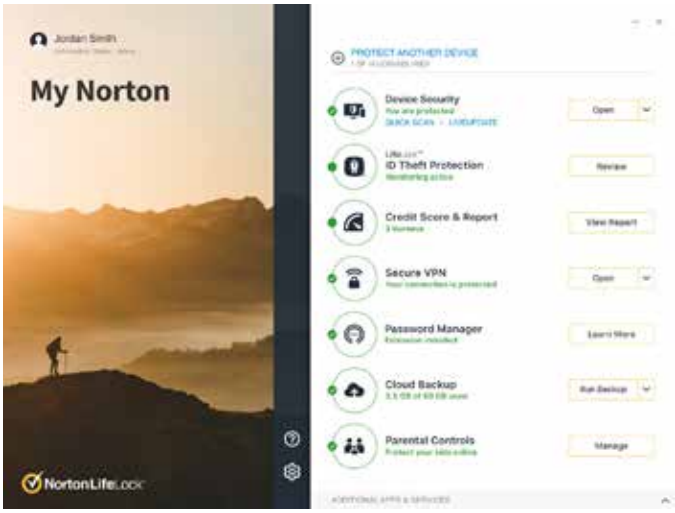
Already a LifeLock member? After activation and logging in with your newly created credentials, your new plan will sync with your previous account.

Already a Norton member? Merge your accounts by clicking on "Sign in" rather than creating a new account.

YOUR PERSONALIZED DASHBOARD

Your dashboard will walk you through activating the key features of your membership and gives you a quick snapshot of your account. You'll see important notifications that may need your attention at the top.

	COST
Employee Only	$17.99
Employee + Family	$32.98



REVIEW AND MANAGE YOUR ALERTS ON-THE-GO

- Credit, Checking & Savings
- Account Activity Alerts
- 401k & Investment Account Activity Alerts
- Identity & Social Security Number Alerts
- Bank & Credit Card Activity Alerts
- Unsafe website and compromised Wi-Fi network notifications

my.norton.com | 800-607-9174

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCSouthwest@usi.com | Toll Free: 855-874-0110
Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

IMPORTANT CONTACTS

BENEFIT	CARRIER	CONTACT	WEBSITE
Benefit Resource Center (BRC)	USI	855-874-0110	**BRCsouthwest@usi.com**
Medical	BCBSTX	800-521-2227	**BCBSTX.com**
Telemedicine	MDLive	888-680-8646	**MDLIVE.com/BCBSTX**
Dental	BCBSTX	800-521-2227	**BCBSTX.com**
Vision	VSP	800-877-7195	**VSP.com**
Life/Disability	UNUM	866-779-1054	Filing a Life, AD&D or Disability Claim through the MyUnum for Clients Portal **services.unum.com**
Accident Insurance, Critical Illness, Hospital Indemnity	UNUM	800-635-5597	**unum.com**
HSA and FSA	HSA Bank	800-357-6146	**www.hsabank.com**
ID Theft	Norton LifeLock	800-607-9174	**my.norton.com**
Employee Assistance Program	UNUM	800-854-1446	**unum.com/lifebalance**
Travel Assistance	UNUM	Within the U.S.: 1-800-872-1414 Outside the U.S.: +609-986-1234	**unum.com**
Be Well	UNUM	800-635-5597	**unum.com**
Life Planning, Financial & Legal Resources	UNUM	800-422-5142	**healthadvocate.com/ unumlifeplanning**
HR	Enstor HR Department		**HR@enstorinc.com**

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- HDHP w/ HSA: $3,500/$7,000 Individual/Family deductible, then 20% coinsurance after deductible
- PPO: $1,500/$4,500 Individual/Family deductible, then 20% coinsurance after deductible

NEWBORNS ACT DISCLOSURE – FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Effective January 1, 2026
Enstor HR Department
Enstor Operating Company, LLC
2107 City West Boulevard, Suite 1500
Houston, Texas United States 77042
281-374-3050
HR@enstorinc.com

Your Information. Your Rights. Our Responsibilities.

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****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

Effective January 1, 2026
Enstor HR Department
Enstor Operating Company, LLC
2107 City West Boulevard, Suite 1500
Houston, Texas United States 77042
281-374-3050
HR@enstorinc.com

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Operating Company, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Enstor Operating Company, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Enstor Operating Company, LLC has determined that the prescription drug coverage offered by the Enstor Operating Company LLC Employee Benefit Plan for the plan year 2026 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Enstor Operating Company LLC Employee Benefit Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Enstor Operating Company LLC Employee Benefit Plan creditable coverage.
- You may stay in the Enstor Operating Company LLC Employee Benefit Plan and also enroll in a Medicare prescription drug plan. The Enstor Operating Company LLC Employee Benefit Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Enstor Operating Company LLC Employee Benefit Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Enstor Operating Company LLC Employee Benefit Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

You should also know that if you drop or lose your current coverage with Enstor Operating Company, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Enstor Operating Company, LLC changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Effective January 1, 2026
Enstor HR Department
Enstor Operating Company, LLC
2107 City West Boulevard, Suite 1500
Houston, Texas United States 77042
281-374-3050
HR@enstorinc.com

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	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – 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	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)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**

Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Effective January 1, 2026
Enstor HR Department
Enstor Operating Company, LLC
2107 City West Boulevard, Suite 1500
Houston, Texas United States 77042
281-374-3050
HR@enstorinc.com

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name	4. Employer Identification Number (EIN)	
Enstor Operating Company, LLC	03-0483265	
5. Employer address	6. Employer phone number	
2107 City West Boulevard, Suite 1500		
7. City	8. State	9. ZIP code
Houston	TX	77042
10. Who can we contact about employee health coverage at this job?		
Enstor HR Department		
11. Phone number (if different from above)	12. Email address	
281-374-3050	HR@enstorinc.com	

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

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:

    All Full-time eligible employees, working 30+ hours per week.

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legal spouse or domestic partner, children

  - ☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly


ENSTON