ORENDA EDUCATION

MEDICAL BENEFITS

2026 - 2027

YOUR HEALTH JOURNEY

30 DAYS

ON YOUR JOURNEY TO HEALTH & WELLNESS BRING ALONG YOUR FAMILY MEMBERS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are a full-time employee scheduled to work at least 30 hours per week. Newly eligible employees must satisfy an eligibility waiting period of 30 days and are eligible for benefits the first of the month following your date of hire. You have 30 days to elect benefits.

FAMILY MEMBER ELIGIBILITY

Benefits eligible employees may enroll the following dependents:

- Your spouse or domestic partner
- Children up to age 26, including natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26

QUALIFYING EVENTS

You have 30 days from the date of a qualifying life event to modify any current benefit elections. Modifications in your benefits must be consistent with the change in your family status.

A qualifying event is an event that allows you to make specified changes to your benefit enrollment status outside of the regular benefit enrollment period(s). If you experience a qualifying event and would like to enroll, change or drop your benefits, you must do so in the benefits platform within 30 days.

GOOD TO KNOW

- Student status is no longer required for a dependent to be eligible
- Documentation *may* be required to prove eligible dependent status (domestic partner registration, birth certificate, etc)

MEDICAL

Excelsior Higher Care

Orenda Ed is pleased to offer medical coverage through Excelsior Higher Care by Ovation Health. Employees now have access to a concierge team of doctors to oversee your healthcare journey.

Employees have two Excelsior Higher Care medical plans to choose from:

Excelsior Higher Care Platinum Plan

Excelsior Higher Care High Deductible Plan

2 PLANS TO CHOOSE FROM

You can choose to enroll in either the Excelsior Platinum Plan or the Excelsior High Deductible Plan. While the Platinum plan costs more out of your paycheck, you will pay less or nothing at all when you go see a doctor through Coordinated Care. The high deductible plan costs less out of your paycheck, but costs more if and when you go see a doctor. You can select the plan that works best for you and your family. Remember, the plan you select will remain in place until next year's open enrollment.

WHO IS EXCELSIOR HIGHER CARE

Excelsior Higher Care is a Health Plan with a fully engaged concierge Patient Advocacy Team. All doctors and hospitals are available to you! Because Excelsior HC allows members to have access to all providers and hospitals, utilizing the Patient Advocacy Team to help you set appointments for care is highly encouraged. And, when you utilize your Patient Advocacy Team, you will always pay less for services, many times $0 cost to you.

1. Communicates directly with Providers, Hospitals, Labs & Imaging about services needing attention.
2. Helps members evaluate past quality of providers & hospitals for the exact services needed.
3. Sets your appointments with doctors and hospitals
4. Facilitates members paying less at providers, hospitals, labs & imaging, $0 cost to you most of the time.
5. Helps you receive prescription drugs to your home, pharmacy, or infusion center.
6. Aids with any communication or bills you may receive for payment from doctors or hospitals.

AT NO COST TO YOU

In-person doctor and hospital visits are covered in full when you use Coordinated Care for you and your family. Go to the doctor for FREE.

COVERED AT 100%

- Doctor visits
- Specialist care
- Preventive care
- Teladoc
- Labwork
- Mental health

AVAILABLE SERVICES

- Provider Recommendations
- Imaging Coordination
- Prescription Delivery
- Cost Negotiation Support
- Billing Assistance

MEDICAL

Excelsior Higher Care

CARE TEAM WITH PATIENT ADVOCACY

The Excelsior Care Team by Ovation Health assists members with coordinating care, negotiating costs for imaging, procedures, high-cost prescriptions and more. They protect members from surprise bills and navigate the healthcare system to ensure members get the best health care.

MEMBER SERVICES

Expert assistance with enrollment inquiries, general benefit questions, ID cards, setting appointments, locating medical services, provider contracting, and coordinating medical authorizations. Our providers and advocates work with members to ensure members receive the proper care at reasonable rates.

LABWORK

Labwork is covered in full and at no cost to you as long as it is scheduled through Coordinated Care and performed at a Quest facility. Your doctor will work with you to send you to a participating Quest facility to ensure you don't pay more than you need to out of your pocket.

HOW DO I USE MY PLAN?

Unlike traditional network-based plans, Excelsior Higher Care allows members to access any doctor or hospital. Before scheduling care, contact the Care Team first.

The Care Team can help you find a provider, schedule appointments, verify coverage, and coordinate care to help reduce your out-of-pocket costs.

HOW COORDINATED CARE WORKS

Getting care is easy with Excelsior Higher Care. Simply contact the Care Team before scheduling services, and they will help guide you through the process.

CONTACT THE CARE TEAM

- Call: 866-549-4199
- Email: membership@ovation-health.com

TELL US WHAT YOU NEED

- Preventive care
- Sick visit
- Specialist
- Imaging or lab work
- Prescription assistance

WE COORDINATE YOUR CARE

- Find a provider
- Schedule appointments
- Verify coverage
- Coordinate authorization when needed

SAVE MONEY & TIME

- Many coordinated services are covered at $0 cost to you
- Protection from surprise bills
- Support every step of the way

EMPLOYEE CONTRIBUTIONS - PER MONTH

Plan	Platinum	High Deductible
Employee Only	$188.00	$0
Employee & Spouse	$762.70	$452.70
Employee & Child(ren)	$655.50	$444.70
Employee & Family	$1,265.50	$965.50

MEDICAL
Excelsior Higher Care

PREVENTIVE CARE

Preventive care is covered at 100% when you visit an in-network provider. Annual physicals, screenings, and immunizations help detect health concerns early and may prevent more serious medical issues.

TELEMEDICINE. ANYTIME. ANYWHERE.

Skip the waiting room and get the care you need wherever you are. Whether it's a routine check-up, follow-up appointments, prescription refill, or minor illness, telemedicine makes it easy to connect with a healthcare provider.

Teladoc offers virtual visits 24/7, so quality healthcare is always just a call, click, or tap away—from home, work, or on the go.

HINGE HEALTH. MOVE BETTER. FEEL BETTER

Hinge Health is a digital musculoskeletal (MSK) care program that helps you prevent and relieve joint and muscle pain—all from the comfort of your home. Whether you're dealing with back, knee, neck, shoulder, hip, or other joint pain, Hinge Health provides personalized support to help you move with confidence.

WITH HINGE HEALTH, YOU CAN ACCESS:

- Personalized exercise therapy tailored to your needs
- Virtual support from licensed physical therapists and health coaches
- Guided exercise sessions with real-time movement feedback
- Programs for back, joint, muscle, and pelvic health
- Convenient care through the Hinge Health mobile app—anytime, anywhere

WHERE SHOULD YOU GO FOR CARE?

	TELEMEDICINE	PRIMARY CARE	URGENT CARE	EMERGENCY ROOM
Best For	Cold, flu, allergies, rashes, headaches, prescription refills	Physicals, preventive care, vaccinations, chronic conditions	Minor injuries, sprains, burns, ear infections, sore throat	Chest pain, difficulty breathing, severe injuries, stroke symptoms
Examples	Cold, flu, sinus infection, allergies	Annual wellness visit, blood pressure check, diabetes management	Sprains, cuts, minor burns, fever	Heart attack, stroke, major trauma
Cost	$0 copay	May require copay/coinsurance	May require copay/coinsurance	May require copay/coinsurance
Availability	24/7	By appointment	Walk-in	24/7

Not sure where to go? Contact the Care Team at 866-549-4199 for assistance.

PRESCRIPTION RX DELIVERED TO YOU

Prescription drugs are administered through EHIM and available at a low cost.

The plan also includes over 1,000 generic maintenance medications at no cost, delivered directly to your home.

The medication list contains over 95% of the top prescribed generic medications including:

- Asthma
- Diabetes
- Mental Health
- High Cholesterol
- High Blood Pressure
- Allergies
- Men's Health
- Women's Health

Need a non-maintenance prescription?

Simply visit one of our 70,000 contracted retail pharmacies to fill your prescription.

MEDICAL Plan Comparison

	Platinum Plan			High Deductible Plan		
	Coordinated Care	Baylor Scott & White (BSW)	Non-Coordinated Care	Coordinated Care	Baylor Scott & White (BSW)	Non-Coordinated Care
Individual / Family Deductible	$0	$4,000/$11,000	$4,000/$11,000	$5,000/$11,000	$7,000/$14,000	$7,000/$14,000
Individual/Family Out of Pocket Maximum	$6,350/$12,500	$7,350/$15,500	$7,350/$15,500	$7,900/$15,000	$9,900/$17,000	$9,900/$17,000
HSA Eligible	No	No	No	Yes	Yes	Yes
Doctor Visits						
Telemedince	$0	$0	$0	$0	$0	$0
Virtual Health	$0	$0	$0	$0	$0	$0
Preventive Visits	$0	$0	$0	$0	$0	$0
Primary Care Visit	$0	$30	$30	$0	$50	$50
Specialist Visit	$0	$50	$50	$0	$75	$75
Office Services						
Office Surgery	$0	$25*	$25	$0*	$25	$25
Imaging	$0	$250*	$250	$0	$250	$250
Labwork	$0	$50*	$50	$0	$50	$50
Care Facilities						
**** Urgent Care**	$75	$75*	$75	$75*	$75*	$75
Emergency Room	$500	$500*	$500	$500*	$500*	$500
Ambulance Services	$250	$250*	$250	$250*	$250*	$250
**** Outpatient Surgery**	$400	$400*	$400	$400*	$400*	$400
**** Hospital Services**	$500/Day	$500/Day*	$500/Day	$500/Day*	$500/Day*	$500/Day
**** Surgeon Fees**	$25	$25*	$25	$25*	$25*	$25
Maternity and Newborn Services						
Maternity	$0	$500/Day*	$500/Day	$500/Day*	$500/Day*	$500/Day
Maternity Office Visit	$0	$25*	$25	$25	$50*	$50
Prescription Drug Benefits						
Tier 1	$5	$5	$5	$5*	$5*	$5*
Tier 2	$10	$10	$10	$10*	$10*	$10*
Tier 3	$20	$20	$20	$20*	$20*	$20*
Tier 4	$50	$50	$50	$50*	$50*	$50*
Tier 5	50%	50%*	50%*	50%*	50%*	50%*

*After Deductible

** Deductible and copays may be waived when care is coordinated with the Member Care Team.

COVERING HEALTH CARE EXPENSES

A Health Savings Account (HSA) is a tax-advantaged account that helps you save and pay for qualified medical expenses. You can contribute pre-tax dollars, the money grows tax-free, and withdrawals for qualified healthcare costs are also tax-free. It's your account to keep forever, and unused funds roll over year after year — even if you change jobs or retire.

WHO IS ELIGIBLE TO OPEN A HSA

A Health Savings Account (HSA) is only available to qualified individuals enrolled in the High Deductible medical plan. Employees who elect to contribute pre-tax dollars to an HSA will need to open an account.

TAX SAVING

You get a triple tax advantage: Contributions are made pre-tax, the money grows tax-free, and withdrawals for qualified medical expenses are also tax-free.

QUALIFIED MEDICAL EXPENSES

Examples of qualified healthcare expenses include deductibles, coinsurance payments and other out-of-pocket costs towards certain medical, mental health, dental, vision and prescription expenses.

The IRS determines what types of expenses qualify for reimbursement from this type of account. A detailed listing of qualified expenses can be found at IRS Publication 969.

IRS 2026 MAXIMUM CONTRIBUTION

Employee Only HDHP Coverage: $4,400

Family HDHP Coverage: $8,750

Eligible individuals aged 55+ at the end of your tax year, your contribution limit is increased by: $1,000

PENALTIES AND FEES

If you are under age 65, any funds used for non-qualified expenses will be taxed at your regular income tax rate and subject to a 20% IRS penalty. Additionally, once you are enrolled in Medicare, IRS rules prohibit you from making any pre-tax contributions to an HSA.

CHANGE ANYTIME

You may change your pre-tax contribution amount anytime during the year (unlike FSAs, which are locked in after enrollment).

INVESTING OPTIONS

Most HSAs allow you to invest your savings in mutual funds or other options, allowing your balance to potentially grow tax-free over time.

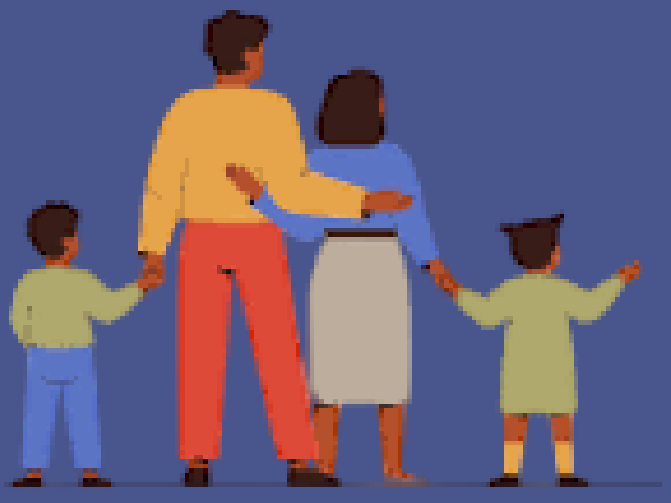
WE'RE HERE FOR YOU

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/ EMAIL	POLICY NUMBER
Medical	Excelsior Higher Care by Ovation Health	(866) 549-4199	www.excelsiorhc.com	Orenda Ed
Telemedicine	Teladoc	(800) 945-4355	www.teladochealth.com	Orenda Ed
Pharmacy/PBM	EHIM	(800) 311-3446	www.ehimrx.com	RX BIN: 5285 RX PCN: ACB
Digital Physical Therapy	Hinge Health	(855) 902-2777	www.hingehealth.com	Orenda Ed

BENEFITS SUPPORT

UBF Consulting is here to support you! If you have any questions about your benefits or would like to talk to someone about a confidential issue, call UBF. The UBF Client Advocacy team will help you with any benefits questions or concerns. UBF can be reached at team@ubf.consulting.

This brochure highlights the main features of the Orenda Education 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. Orenda Education reserves the right to change or discontinue its benefit plans at any time.



Important Notices & Disclosures

1. MEDICARE PART D NOTICE
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Company 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. The Company has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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, your current coverage will not be affected. The drug plan will coordinate with Part D coverage. The current pre-scription plan offers coverage for generic, brand name formulary and brand name non-formulary prescriptions. If you do decide to enroll in a Medicare Prescription Drug Plan and drop your current prescription drug coverage, be aware that you and your dependents may not be able get this coverage back until Open Enrollment.

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 the Company 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.

For more information about this notice or your current prescription drug coverage…contact Human Resources for further information.

NOTE: You will receive this notice annually. You will also receive this notice before the next period you can join a Medicare Drug Plan, and if this coverage through the company changes. You 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 prescription drug plans. For more information about Medicare prescription drug plans:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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).

Date:	09/01/2026
Name of Entity/Sender:	Orenda Education
Contact:	Teresa Moreno
Address:	2101 East Fourth Street, Suite B200 Georgetown , TX 78626
Phone Number:	512.869.3020

2. WOMEN'S HEALTH AND CANCER RIGHTS ACT If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:
- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.
If you would like more information on WHCRA benefits, please contact Human Resources.

3. HIPAA 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 you or your dependents' other coverage). However, you must request enrollment within 30 days after you 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. To request special enrollment or obtain more information, contact Human Resources.

4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS
Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

5. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
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 plan 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
Continue Group Health Plan Coverage
Continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

6. HIPAA PRIVACY NOTICE
This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully. The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. This notice describes the plans' health information privacy policy for your healthcare, dental, personal spending account, and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your healthcare providers.

Our Commitment Regarding Health Information Privacy The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans
The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information About You
The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a healthcare provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.
For Payment. The plans may use and disclose your PHI so claims for healthcare treatment, services, and supplies you receive from healthcare providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Healthcare Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce healthcare costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your healthcare treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your healthcare. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death. As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations
The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims or the identity, description, or location of the person who committed the crime.
Workers Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system and government programs.
Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials 1) for intelligence, counterintelligence, and other national security activities authorized by law, and 2) to enable them to provide protection to the members of the U.S. Government or foreign heads of state, or to conduct special investigations.
Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out healthcare treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address.
To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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

• A power of attorney for healthcare purposes, notarized by a notary public;
• A court order of appointment of the person as the conservator or executor of the individual; or
• An individual who is the parent of a minor child. The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice— The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI
You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints— If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and any of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information
A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.
Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.
Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

7. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're 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 can 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 can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan must cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Your health plan must cover emergency services by out-of-network providers.
- Your health plan must 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.
- Your health plan must count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact HR. The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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).

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.

Contact your state for more information on eligibility.

TEXAS - Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493