PPN

Benefits Guide 2026

January 1, 2026 - December 31, 2026

What's Inside

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 33 for more details.

Welcome to Your Benefits!

At Patient Physician Network, we understand that providing a comprehensive plan of benefits is an important part of your overall compensation and that your benefits are important to your well-being. We hope that you will take the time to understand your benefits and utilize the plans in ways that are cost effective and that will best meet you and your family's needs.

Important Contacts

Coverage	Contact	Phone	Website/Email/Address
Medical	Evry Health	(855) 579-3879	**www.evryhealth.com**
Dental , Vision, Voluntary Life, Voluntary Critical Illness, Voluntary Accident, and Voluntary Hospital Indemnity	Lincoln Financial	800-423-2765	**www.lfg.com**
Director of Shared Services	Shannon Penney	(469) 626-1722	**spenney@Drppg.com**

Eligibility

Who is Eligible?

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this guide. The following family members are eligible for the benefits in this summary: **spouse and/or dependent children**.

How to Enroll?

The first step is to review your current benefit options. Make sure you understand your options, ask questions, and then make your benefit elections. Elections will be captured online using the EASE Benefit Portal (instructions on how to access EASE are included in this guide).

Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status, per the IRS rules and regulations.

When to Enroll?

Current Employees-open enrollment will occur annually during the month of November. The benefits you elect during open enrollment will be effective from January 1, 2026- December 31, 2026.

New Employees: Your benefits will be effective the first of the month following 30 days of employment.

How to Make Changes?

You must notify HR **within 31 days** of a qualifying event in order to make changes. Documentation will be required to verify your qualifying event. You cannot make changes to the benefits you elect until the next open enrollment period unless you have one of the following events:

Qualified Life Event	
Change in marital status	Marriage
	Divorce
	Legal Separation
Change in number of dependents	Birth/adoption
	Change in child's dependent status
	Commencement of termination or adoption proceedings
Change in employment	Change in spouse's benefits or employment status
	Loss of eligibility for other coverage

Enroll In Your Benefits Online: One Step at a Time

Step 1: Log In

Go to **www.employeenavigator.com** and click Login

Returning users: Log in with the username and password you selected.
Click Reset a forgotten password.

First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.

Step 2: Welcome

After you login click Let's Begin to complete your required tasks.

Step 3: Onboarding (for first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click Start Enrollment to begin your enrollments.

TIP: If you hit "Dismiss, complete later" you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking "Start Enrollments"

Step 4: Start Enrollments

After clicking Start Enrollment, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP: Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under Who am I enrolling?

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click Select Plan underneath the plan cost.

Click Save & Continue at the bottom of each screen to save your elections.

If you do not want a benefit, click Don't want this benefit? at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP: If you miss a step you'll see Enrollment Not Complete in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click Start Tasks. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

Medical - Evry Network

Welcome to the Evry Network

The Evry network includes thousands of world-class providers across the state of Texas to meet the healthcare needs of you and your family.

Download the Evry App to Get Started:

Get Personal Care

Get one-on-one attention from your personal Care Guide and tons of additional benefits from your Evry Care Plan.

Access free digital wellness programs for issues ranging from managing depression and anxiety to curbing addiction and reducing joint pain.

Earn up to $1,000 per year simply by investing in yourself.

Understand your Benefits

View your medical coverage in an easy and transparent way. Access, download and upload all your health plan information and documents. View your copays, deductibles and out-of-pocket expenses.

Control your Prescriptions

Find participating nationwide and regional pharmacies. View and search your medications on the Evry Formulary.

Access 24/7 Virtual Care

Talk to a doctor or therapist for free over the phone or by video anytime, anywhere. These providers can even order prescriptions.

Find Providers

Find the right doctors, specialists and facilities for you and your family.

ID Card

View and share your digital Member ID card.

Manage Claims

Review claims and access your Explanation of Benefits.

Manage Household

Manage your family's insurance benefits all in one place.

Medical

Explore your plan options.

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this guide. The following family members are eligible for the benefits in this summary: **spouse and/or dependent children**.

EPO

Our EPO Premier plan has no deductibles, and no copays (except ER). It's designed to give you and your family access to the highest quality providers and health systems.

PPO

The same great plan as EPO Premier but with thousands of additional in-network providers and health systems and out-of-network benefits.

EPO HDHP

A more traditional but still benefit rich plan with a deductible and limited copays. PPN's HDHP plan options are NOT HSA Compliant.

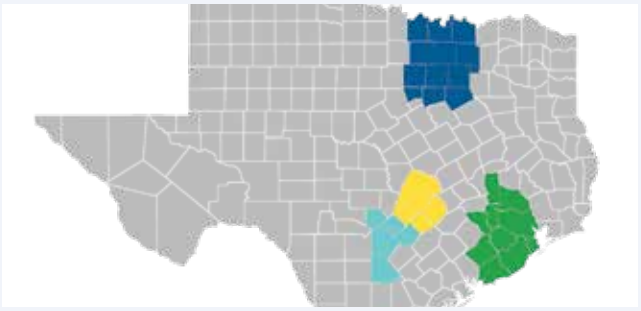
PPO HDHP

The same great plan as EPO HDHP but with thousands of additional in-network providers and health systems and out-of-network benefits. PPN's HDHP plan options are NOT HSA Compliant.

The Evry Health Network

- No referrals needed! Go to any in-network doctor anywhere anytime
- Visit the provider directory at **www.evryhealth.com/providerdirectory**

Plans starting at:	
Doctor Visits	$0
Specialists	$0
Deductible	$0
Imaging	20%
Prescriptions starting at	$0
Labs	$0
24/7 Telehealth (every day, urgent care & mental health)	$0



Dallas/Fort Worth **Austin**

Houston **San Antonio**

Medical – Evry Health

Total Monthly Cost	PPO Premier	PPO HDHP	EPO Premier	EPO HDHP	EPO HDHP w/ Gap Plan	PPO HDHP w/ Gap Plan
Employee Only	$883.02	$632.94	$706.42	$506.36	$372.00	$461.00
Employee + Spouse	$1,850.25	$1,494.05	$1,480.20	$1,195.25	$731.00	$904.00
Employee + Child(ren)	$1,677.73	$1,123.46	$1,342.18	$898.77	$654.00	$810.00
Employee + Family	$2,737.35	$1,927.54	$2,189.87	$1,542.03	$1,083.00	$1,341.00

Evry Plan Comparison	EPO Premier	EPO HDHP
	IN-NETWORK ONLY; NO OUT-OF-NETWORK COVERAGE	IN-NETWORK ONLY; NO OUT-OF-NETWORK COVERAGE
You Pay		
Deductible	None	$3,000 / $6,000
Coinsurance and co-payments	Various, see below	Various, see below
Annual Out-of-pocket Maximum Pharmacy is embedded	$5,250 / $10,500 $1,500 / $3,000 (pharmacy)	$7,000 / $14,000 $1,500 / $3,000 (pharmacy)
Preventive Care (see schedule)	Covered at 100%	Covered at 100% (deductible does not apply)
Office Visits		
Telemedicine Interactions	Covered at 100%	Covered at 100%
Primary Care & Specialist-based Primary Care	Covered at 100%	Covered at 100%*
Home Visits by PCP / SCP	Covered at 100%	Covered at 100%*
Nutritionist	Covered at 100%	Covered at 100%*
Physical Therapy	Covered at 100%	Covered at 100%*
Behavioral Health	Covered at 100%	Covered at 100%*
Emergency Room	$300 copayment & 20% coinsurance	$300 copayment & 40% coinsurance*
Urgent Care	20% coinsurance	40% coinsurance*
Hospital Admission (includes medical & behavioral health)	20% coinsurance	40% coinsurance*
Other Physician Fees	20% coinsurance	30% coinsurance*
Outpatient Diagnostic Labs / X-Rays	20% coinsurance	40% coinsurance*
High Tech Imaging	20% coinsurance	40% coinsurance*
Outpatient Surgery	20% coinsurance	25% coinsurance*
Maternity		
Routine Prenatal Care	Covered at 100%	Covered at 100% (deductible does not apply)
Inpatient Hospital	20% coinsurance	40% coinsurance*
Prescription Drugs		
Retail (up to 30-day supply)	No member cost for generic; 20% coinsurance for brand up to RX out of pocket max	No member cost for generic; 35% coinsurance for brand* up to RX out of pocket max
Mail Order (up to 90-day supply)	No member cost for generic; 20% coinsurance for brand up to RX out of pocket max	No member cost for generic; 35% coinsurance for brand* up to RX out of pocket max
Specialty & Injectables	20% coinsurance for brand up to RX out of pocket max	35% coinsurance* for brand up to RX out of pocket max
Durable Medical Equipment (DME) / Orthotics & Prosthetics	20% coinsurance for prosthetics that are surgically implanted; all others 50% coinsurance	20% coinsurance for prosthetics that are surgically implanted; all others 50% coinsurance*

* After deductible

	PPO Premier		PPO HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
You Pay				
Deductible	None		$3,000 / $6,000	
Coinsurance and co-payments	Various, see below		Various, see below	
Annual Out-of-pocket Maximum Pharmacy is embedded	$5,250 / $10,500 $1,500 / $3,000 (pharmacy)		$7,000 / $14,000 $1,500 / $3,000 (pharmacy)	
Preventive Care (see schedule)	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Office Visits				
Telemedicine Interactions	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Primary Care & Specialist-based Primary Care	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Home Visits by PCP / SCP	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Nutritionist	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Physical Therapy	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Behavioral Health	Covered at 100%	40% coinsurance	Covered at 100%*	50% coinsurance*
Emergency Room	$300 copayment & 20% coinsurance	$300 copayment & 20% coinsurance	$300 copayment & 40% coinsurance*	$300 copayment & 40% coinsurance*
Urgent Care	20% coinsurance	20% coinsurance	40% coinsurance*	40% coinsurance*
Hospital Admission (includes medical & behavioral health)	20% coinsurance	40% coinsurance	40% coinsurance*	50% coinsurance*
Other Physician Fees	20% coinsurance	40% coinsurance	25% coinsurance*	50% coinsurance*
Outpatient Diagnostic Labs / X-Rays	20% coinsurance	40% coinsurance	40% coinsurance*	50% coinsurance*
High Tech Imaging	20% coinsurance	40% coinsurance	40% coinsurance*	50% coinsurance*
Outpatient Surgery	20% coinsurance	40% coinsurance	25% coinsurance*	50% coinsurance*
Maternity				
Routine Prenatal Care	Covered at 100%	40% coinsurance	Covered at 100% (deductible does not apply)	50% coinsurance*
Inpatient Hospital	20% coinsurance	40% coinsurance	40% coinsurance*	50% coinsurance*
Prescription Drugs				
Retail (up to 30-day supply)	100% coinsurance, ded does not apply (generics) 20% coinsurance for brand up to RX out of pocket max		100% coinsurance, ded does not apply (generics) 35% coinsurance for brand* up to RX out of pocket max	
Mail Order (up to 90-day supply)	100% coinsurance, ded does not apply (generics) 20% coinsurance for brand up to RX out of pocket max		100% coinsurance, ded does not apply (generics) 35% coinsurance for brand* up to RX out of pocket max	
Specialty & Injectables	20% coinsurance		35% coinsurance for brand*	
Durable Medical Equipment (DME) / Orthotics & Prosthetics	20% coinsurance for prosthetics that are surgically implanted; all others 50% coinsurance	40% coinsurance for prosthetics that are surgically implanted; all others 50% coinsurance	20% coinsurance for prosthetics that are surgically implanted; all others 50% coinsurance	50% coinsurance*

* After deductible

*Note: You are only enrolled in the Gap Plan if you chose the one of these plans below.

	EPO HDHP Gap Plan	PPO HDHP Gap Plan	
	IN-NETWORK ONLY. NO OUT-OF-NETWORK COVERAGE	IN-NETWORK	OUT-OF-NETWORK
	You Pay		
Deductible	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Coinsurance and co-payments	Covered at 100%	Covered at 100%	Covered at 100%
Annual Out-of-pocket Maximum Pharmacy is embeded	$10,000/$20,000 $1,500 RX OOP Max	$10,000/$20,000 $1,500 RX OOP Max	$10,000/$20,000 $1,500 RX OOP Max
Preventive Care (see schedule)	Covered at 100%	Covered at 100%	Covered at 100%
Office Visits			
Telemedicine Interactions	Deductible then 100%	Deductible then 100%	Deductible then 100%
Primary Care & Specialist-based Primary Care	Deductible then 100%	Deductible then 100%	Deductible then 100%
Home Visits by PCP / SCP	Deductible then 100%	Deductible then 100%	Deductible then 100%
Nutritionist	Deductible then 100%	Deductible then 100%	Deductible then 100%
Physical Therapy	Deductible then 100%	Deductible then 100%	Deductible then 100%
Behavioral Health	Deductible then 100%	Deductible then 100%	Deductible then 100%
Emergency Room	$300 Copay + Deductible	$300 Copay + Deductible	$300 Copay + Deductible
Urgent Care	Deductible then 100%	Deductible then 100%	Deductible then 100%
Hospital Admission (includes medical & behavioral health)	Deductible then 100%	Deductible then 100%	Deductible then 100%
Other Physician Fees	Deductible then 100%	Deductible then 100%	Deductible then 100%
Outpatient Diagnostic Labs / X-Rays	Deductible then 100%	Deductible then 100%	Deductible then 100%
High Tech Imaging	Deductible then 100%	Deductible then 100%	Deductible then 100%
Outpatient Surgery	Deductible then 100%	Deductible then 100%	Deductible then 100%
Maternity			
Routine Prenatal Care	Deductible then 100%	Deductible then 100%	Deductible then 100%
Inpatient Hospital	Deductible then 100%	Deductible then 100%	Deductible then 100%
Prescription Drugs			
Retail (up to 30-day supply)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)
Mail Order (up to 90-day supply)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)
Specialty & Injectables	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)
Durable Medical Equipment (DME) / Orthotics & Prosthetics	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)	100% coinsurance, ded does not apply (Generics)

About Gap

Our Supplemental Medical Expense (Gap) Insurance reimburses eligible out-of-pocket medical expenses incurred in inpatient settings, such as the deductibles,copays, and coinsurance you owe out of pocket.

Gap coverage is offered guaranteed issue; you do not have to answer any medical questions to qualify for coverage. You may opt for coverage for your dependent spouse or child(ren), as long as they participate in your employer's underlying major medical plan.

Note: Gap insurance is not meant to replace health insurance. It is only available if an employer has a group health insurance plan in place.

Only 39% of U.S. adults say they could cover the cost of a $1,000 emergency room visit using savings.

How it works

Gap coverage is easy to use and understand. Once enrolled, you receive an ID card to present to your medical provider at the time of service. Your provider can submit the claim to our third party benefit administrator on your behalf. Once that claim is processed, payment will be sent to your provider.

[1]Bankrate Financial Security Index 2021

Supplemental Medical Expense (Gap) Insurance

Underwritten by Globe Life And Accident Insurance Company

Globe Life Group Benefit's Supplemental Medical Expense (Gap) Insurance reimburses eligible out-of-pocket medical expenses incurred under the group health plan, such as deductibles, copays, and coinsurance.

Benefit	$2000 Deductible In Patient Gap Only
Inpatient Hospital Benefit	
Per Insured per Benefit Year	$8,000
Per Immediate Family per Benefit Year	$8,000
Outpatient Benefit	
Per Insured per Benefit Year	$0
Per Immediate Family per Benefit Year	$0
Limitations	
Supplemental Medical Deductible **Per Insured per Benefit Year** **Per Immediate Family per Benefit Year**	 $2,000 $4,000
Deductible	Traditional Deductible

For full description of all terms, conditions, exclusions and limitations, please request a copy of the Group Policy and Certificate.

Key features of Gap:

- Reimburses eligible out-of-pocket medical expenses up to a specific benefit amount per year.
- Guaranteed issue (no medical questions)
- Optional dependent coverage (for spouse and children)

Care Guides

Personalized care for you and your family.

As part of your personalized Care Plan, you'll receive a wide range of resources, tools and rewards that are outside of your normal plan benefits. As part of your Care Plan, you'll be assigned your own personal Care Guide.

These guides are typically nurses or other medical professionals. You'll be speaking to the same medical team each time you call or reach out through the Member Portal, not an offshore call center.

In addition to being able to talk to your free Care Guide, you can see a board certified and Evry vetted doctor online 24/7 through your Member Portal or Evry Mobile App.

These visits are covered entirely by Evry.

What Can Care Guides Do?

1

Physicians & Procedures

- Match a member with the right doctor or specialist for their condition
- Find an in-network doctor
- Schedule a doctor's appointment
- Find ways to save time and money
- Help a member prepare for procedures
- Help with admissions, discharges, and follow-up care

2

Benefits & Education

- Explain your Care Plan and personalized benefits
- Help a member explore the Member Portal and its features
- Provide educational information
- Answer questions about your benefits and health plan coverage

Additional Benefits - Evry Health

What's Included in the Plan

24/7 Telehealth

Unlimited FREE telehealth services through Doctor on Demand for medical/behavioral health.

Preventive Care at home

Free at-home health screening program in partnership with Quest® Diagnostics. This program helps you monitor key health markers right from the comfort of your home.

Expanded Preventive Care

Preventative care with Evry means 100% coverage for physical therapy, nutritional counseling, and mental health services.

National Partner Network

These plans protect you in case of emergencies no matter where you are in the United States

Referrals Not Required

You'll never need to get a referral from your PCP before seeking care.

Pharmacy Benefits

Embedded pharmacy benefit means you will not pay more than $1500/$3000 in pharmacy spend. Broad Nationwide Pharmacy network to ensure you receive the care you need no matter where you are.

Evry Prescription Drugs

Prescriptions starting at

$0

2026 is the Year of FREE Prescriptions

Generic prescriptions will cost you nothing! Below is a sample of medications that will cost $0.

Please visit **www.evryhealth.com/formulary** for formulary lookup.

Acid Reflux

- Omeprazole (Generic Prilosec)
- Famotidine (Generic Pepcid)
- Pantoprazole (Generic Protonix)

Allergy

- Cetirizine (Generic Zyrtec)
- Promethazine (Generic Phenadoz, Phenergan, and Promethegan)
- Ketotifen (Generic Alaway and Zaditor)

Antibiotics

- Levofloxacin (Generic Levaquin and Quixin)
- Amoxicillin (Generic amoxil)
- Sulfamethoxazole/Trimethoprim (Generic Bactrim, Septra, and Sulfatrim)
- Bacitracin (Generic Baciguent)

Antifungals

- Fluconazole (Generic Diflucan)
- Ketoconazole (Generic Extina and Nizoral)

Anti-inflammatory Management

- Allopurinol (Generic Lopurin and Zyloprim)
- Indomethacin (Generic Indocin and Tivorbex)

Anxiety and Depression

- Buspirone (Generic Buspar)
- Escitalopram (Generic Lexapro)

Blood Pressure

- Lisinopril (Generic Prinivil, Zestril)
- Amlodipine (Generic Norvasc)
- Losartan (Generic Cozaar)

Cardiovascular Health

- Lisinopril (Generic Prinivil, Zestril)
- Losartan (Generic Cozaar)
- Metoprolol (Generic Lopressor)
- Nitroglycerin (Generic Nitro-Dur, Nitrolingual, and Nitrostat)

Cholesterol

- Atorvastatin (Generic Lipitor)

Diabetes

- Metformin (Generic Glucophage)
- Glyburide (Generic Micronase)

Inhaler

- Albuterol (Generic Ventolin, Proair, Proventil)

Pain Medicine

- Gabapentin (Generic Neurotin)
  Hydrocodone (Generic Acetaminophen)

Respiratory Health

- Albuterol (Generic Accuneb)
- Levalbuterol (Generic Xopenex)

Sedatives/Hypnotics

- Lorazepam (Generic Ativan)
- Zolpidem (Generic Edluar, Ambien, Intermezzo)

Thyroid

- Levothyroxine (Generic Synthroid, Levoxyl)

Urinary Antispasmodics

- Oxybutynin (Generic Ditropan)
- Dicyclomine (Generic Bentyl)

Evry Rewards

Earn up to $1,000 a Year By Investing in Yourself.

Sign up for free health and wellness programs, connect your wearable device, complete health questionnaires, and earn rewards for healthy actions based on your Care Plan. Rewards are loaded onto your Evry Health Reward Card, which works like a credit card for approved purchases.

How It Works

- Visit **evryhealth.com/login** and register using your Member ID.
- View your Care Plan and see available rewards.
- Complete actions to load dollars to your card.
- Talk to your Care Guide for tips and extra opportunities.
- Check back often for new ways to earn.

Evry Rewards Card

One Card. Thousands of Approved Products

- **Baby Care:** Foods, wipes, diapers
- **Eye Care:** Contacts, drops, glasses
- **Groceries:** Bread, milk, fruits & vegetables
- **Over-the-Counter:** Pain relief, allergy, cold/flu meds
- **Nursing:** Diabetes care, insulin, pumps
- **Family Planning:** Condoms, pregnancy tests
- **Wellness:** Vitamins, nutrition bars
- **Personal Care:** Deodorant, first aid, oral care

Track your balance and find eligible items anytime with the Evry Mobile App.

Use your card at over 62,000 retailers, including CVS, Walmart, Kroger, Target, H-E-B, Walgreens, Dollar General, and more.

CVS pharmacy · DOLLAR GENERAL · FAMILY DOLLAR · Kroger · Walmart · TARGET · H-E-B · Walgreens

Evry Programs

Free Digital Wellness Solutions from Evry

Evry members receive a personalized care plan full of free resources to help you live above and beyond the standard insurance benefits.

A beautiful mobile-app gives you easy access to Evry partner programs including customer support and a dedicated nursing care team.

$0 Unlimited access to the programs you need to be happier and healthier.

digbi health
Making chronic illness optional

joint academy
All-in-one solution for treating chronic joint and back pain

MAVEN
Fertility, pregnancy, postpartum, and parenthood support for women

meomind
On-demand pre-recorded therapy sessions

Nightingale Health
Virtual respiratory care with a smart wearable lung tracker

Nurishd
A personalized Nutrition Care Platform

omada
Support for diabetes, hypertension, weight loss, and joint & muscle pain

OSARA HEALTH
Support and caregivers for cancer patients

Pelago
Smoking, alcohol, and substance abuse support

Rula
A national mental-health platform

Somnology
Cost-effective, comprehensive solution for managing sleep disorders

Visana
Virtual women's health clinic for women at every stage of life

vori health
A physician-led, virtual-first MSK care model

Dental

Dental Network: Classic	Low Plan	High Plan
Plan Benefit **Type 1** **Type 2** **Type 3**	 100% 80% 50%	 100% 80% 50%
Deductible	$50/Calendar Year Waived Type 1 3 Family Maximum	$50/Calendar Year Waived Type 1 3 Family Maximum
Maximum (per person)	$2,000/Calendar Year	$3.000/Calendar Year
PPO	A New Choice Plus	Passive PPO
Allowance **Type 1** **Type 2** **Type 3**	 Discounted Fee (MAC)* Discounted Fee (MAC)* Discounted Fee (MAC)*	 90th U&C* 90th U&C* 90th U&C*
Maximum Rewards	N/A	Included
Waiting Period	None	None
Annual Open Enrollment	Included	Included
Orthodontia Summary		
Plan Benefit	50%	50%
Children to age 19	Yes	Yes
Lifetime Maximum (per person)	$1,500	$1,500
Waiting Period	None	None

Allowance All Plan Designs: In Network, discounted fee. Out of Network, U&C.
* Please refer to the following page for explanation of MAC vs U&C.

Total Monthly Cost	Low Plan			High Plan		
	Total Monthly Cost	Semi-Monthly Rates Per Pay Period	Bi-Weekly Rates Per Pay Period	Total Monthly Cost	Semi-Monthly Rates Per Pay Period	Bi-Weekly Rates Per Pay Period
Employee Only	$32.00	$16.00	$14.77	$48.39	$24.19	$22.33
Employee + Spouse	$62.72	$31.36	$28.95	$93.43	$46.71	$43.12
Employee + Child(ren)	$87.87	$43.93	$40.55	$115.83	$57.91	$53.46
Employee + Family	$118.59	$59.29	$54.73	$162.46	$81.23	$74.98

Maximum Allowable Charge (MAC) vs Usual & Customary (U&C)

Dental Low Plan = Maximum Allowable Charge (MAC)

When a dentist is on a network, they agree to offer their services at a discounted rate. Ameritas targets a 10-35% discount off the median cost in an area for the providers on their network. This is referred to as the MAC allowance because it is the maximum allowable charge a PPO provider can bill to a member. Employees who select an Ameritas provider generally enjoy looking at their explanation of benefits (EOB) and seeing how much the provider has been required to lower their fees. **MAC is a limit on what a PPO provider can charge the member**

Dental High Plan = Usual & Customary (U&C)

- Utilizes the 90th percentile of U&C (9 out of 10 dentists' charges will fall at or below the amount RSL allows for a particular procedure).
- We use an internal claims database as well as data from a nationally recognized independent data source to ensure our allowances meet the highest industry standards.
- U&C allowances are updated approximately every 12 months..
- This plan utilizes the ZIP code of the dental provider in determining allowances. This ensures that plan members who live in a lower-cost rural area but choose a dentist in a high-cost metropolitan area (or vice versa) will be reimbursed based on the appropriate charges for the dentist's XIP code area.

Dental Covered Procedure Summary

Dental Network: Classic	Low Plan	High Plan
Plan Design Summary	100/80/50 $50/Calendar Year Waived Type 1 3 Family Maximum $2,000	100/80/50 $50/Calendar Year Waived Type 1 3 Family Maximum $3,000

Type 1 Procedure (Frequency)	Type 2 Procedure (Frequency)	Type 3 Procedure (Frequency)
• Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 12 months) • Sealants (age 13 and under) • Space Maintainers	• Fillings for Cavities • Restorative Composites (anterior and posterior teeth) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Implants • Prosthodontics: fixed bridge; removable complete/partial dentures (1 in 10 years)

Vision

Plan: Spectera Vision		
	SPECTERA CHOICE NETWORK + AFFILIATES	OUT OF NETWORK
Annual Eye Exam	100% After $10 Copay	Up to $40
Lenses (per pair)		
Single Vision	100% After $10 Copay	Up to $40
Bifocal	100% After $10 Copay	Up to $60
Trifocal	100% After $10 Copay	Up to $80
Lenticular	100% After $10 Copay	Up to $80
Progressive	See lens options	N/A
Frame Allowance	$130 plus 30% of balance	Up to $40
Frequencies		
Exam/Lens/Frames	12/12/24 Based on date of service	12/12/24 Based on date of service
Deductible, Maximum		
Deductibles	$10 Exam $10 Eye Glass Lenses or Frames*	$10 Exam $10 Eye Glass Lenses or Frames
Maximum per benefit period	None	None
Contact Lenses		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Elective Contacts	Up to $125	Up to $105
Medically Necessary Contacts	100% After $10 Copay	Up to $210

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

Total Monthly Cost	Spectera Choice Network + Affiliates		
	Total Monthly Cost	Semi-Monthly Rates Per Pay Period	Bi-Weekly Rates Per Pay Period
Employee Only	$7.79	$3.89	$3.59
Employee + Spouse	$15.20	$7.60	$7.01
Employee + Child(ren)	$13.68	$6.84	$6.31
Employee + Family	$21.08	$10.54	$9.72

Voluntary Group Accident Insurance

Voluntary group accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

Eligibility

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse or domestic partner.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

Benefit Amount

See full schedule of benefits on the following page.

Contribution Requirements

Coverage is 100% Employee Paid. Benefit payments are not reduced by any other insurance you may have with other companies.

Features

- Health Assessment Benefit of $50
- Covers child sports injuries at 25%
- Includes an Accidental Death benefit
- Portability
- 24-Hour Coverage

Total Monthly Cost	
Employee Only	$11.00
Employee + Spouse	$22.00
Employee + Child(ren)	$18.00
Employee + Family	$27.00

To Obtain the Semi-Monthly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 24

To Obtain the Bi-Weekly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 26

Voluntary Group Accident Insurance Full Benefits

Benefits	Amount
Ambulance	$150 Ground, $750 Air
Blood, Plasma and Platelets	$300
Burns	To $1,600 for 2nd degree burns; To $12,800 for 3rd degree burns; Skin Graft: 50% of benefit payable for burns
Chiropractic Services (per visit)	$50 per session, 6 sessions maximum
Coma	$7,500
Concussion	$150
Dental Injury	$300 for Crown; $100 for Extraction
Diagnostic Exams	$200 per CT/MRI scan
Dislocation	To $5,200 for Non-surgical; To $10,400 for Surgical; Partial: 50% of full dislocation; Multiple: 200% of highest dislocation benefit
Emergency Treatment	
Epidural Anesthesia Injection (per injection)	$150, 1 Maximum
Eye Injury	$150 for removal of foreign object, $300 for surgical repair
Fractures	To $5,000 for Non-surgical; To $10,000 for Surgical repair; Chip fracture: 50% of non-surgical benefit, multiple fractures; 200% of highest sustained fracture
Initial Hospital Admission	$1,000
Initial Intensive Care Unit (ICU) Hospital Admission	$2,000
Hospital Confinement (per day)	$200, 365 days maximum
Intensive Care Unit (ICU) Confinement (per day)	$400, 15 days maximum
Lacerations	To $800
Lodging (per day)	$150 per day up to 30 days if more than 100 miles from residence
Medical Appliances	$150
Organized Youth Sports Benefit	25% of the benefit amount
Paralysis	$32,500 quadriplegia, paraplegia, hemiplegia
Physical Therapy (per session)	$50, Up to 10 sessions
Physician Visit	$75 Initial, $75 Follow-up
Prosthesis	$750 for one, $1,500 for two or more
Rehabilitation Facility Confinement (per day)	$100, 30 days maximum
Surgery	$575 for Arthroscopic; $1,750 for Cranial; $200 for Hernia; $250 for Conscious Sedation; $450 for General Anesthesia; $450 for Knee Cartilage; $450 for Ligaments, Tendons, Rotator cuff; $750 for Ruptured Disc; $1,500 for Abdominal or Thoracic
Transportation	$450 if more than 100 miles from residence
X-Rays	$50
Wellness (Health Screening) Benefit	
Wellness (Health Screening)	$50

Voluntary Group Critical Illness Insurance

Voluntary group critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care.

Eligibility

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse or your domestic partner.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

Benefit Amount

- **Employee:** Choose from a benefit of $5,000 to a maximum of $30,000 in $5,000 increments.
- **Spouse:** Choose from a benefit of $5,000 to a maximum of $30,000 in $5,000 increments, not to exceed 100% of approved employee amount.
- **Child(ren):** 50% of approved employee amount up to a maximum of $15,000.

Guaranteed Issue

- **Employee:** $30,000
- **Spouse:** $30,000
- **Child(ren):** $15,000

Contribution Requirements

Coverage is 100% Employee Paid.

Features

- **Lifetime Maximum Benefit**: 100% of Insurance Amount
- **Subsequent Occurrence Benefit**: 100% of benefit if diagnosed 3 months or later
- **Recurrence Benefit (Same Illness)**: 100% of benefit if diagnosed 6 months or later
- **FMLA / MSLA Continuation**
- **Portability**
- **Wellness (Health Screening) Benefit**: $50

Employee and Spouse Monthly Premiums

Age Range (attained age)	Under 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Above 70
Premium Monthly Rate	$0.370	$0.370	$0.590	$0.740	$1.040	$1.590	$2.240	$3.120	$4.610	$6.900	$11.270

To Obtain the Bi-Weekly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 26.

To Obtain the Semi-Monthly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 24.

Benefit Outline

Diagnosis Adult	Benefit
Acute Respiratory Distress Syndrome	25%
Alzheimer's Disease	100%
Benign Brain Tumor	100%
Carcinoma In Situ	25%
Coma	100%
Coronary Disease	25%
Heart Attack	100%
Invasive Cancer	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Major Organ Failure	100%
Motor Neuron Disease(ALS)	50%
Multiple Sclerosis	100%
Paralysis	100%
Parkinson's Disease	100%
Severe Brain Damage	100%
Skin Cancer	5%
Stroke	100%
Diagnosis Child	
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Downs' Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

To Obtain the Bi-Weekly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 26

To Obtain the Semi-Monthly Rate: Take the amount listed from the benefit amount & your age range x 12 & divide by 24.

Hospital Indemnity Insurance

Voluntary group hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

Eligibility

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse or domestic partner.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

Contribution Requirements

Coverage is 100% Employee Paid.

Features

- No pre-existing conditions exclusions
- No deductibles
- Eligible for continuation of coverage
- Coverage Offered on a Voluntary Basis
- Portability
- FMLA / MSLA Continuation

Total Monthly Cost	
Employee Only	$22.50
Employee + Spouse	$48.73
Employee + Child(ren)	$34.79
Employee + Family	$63.63

Benefits

Hospital Room & Board Benefits	
Room & Board Benefit per Day (30 Daily Benefits per Coverage Year)	$200
Hospital Critical Care Unit Benefits	
Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$400
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Hospital Critical Care Admission Benefit	
One Daily Benefit per Coverage Year	$2,000
Non-Insurance Services	
On-Call Travel Assistance	Included
Core Hospital Benefit	
Hospital Admissions *For the initial day of admission to a hospital for treatment of sickness and injury.*	$1,000 per day for 4 days per calendar year
Hospital Confinement *For each day of confinement in a hospital because of sickness and injury.*	$200 per day for 30 days per calendar year, starting on day 2 of confinement
Hospital ICU Admissions *For the initial day of admission to an ICU for treatment as a result of sickness and injury.*	$2,000 per day for 1 day per calendar year
Hospital ICU Confinement *For each full day or partial day of confinement in an ICU as a result of sickness and injury.*	$400 per day for 30 days per calendar year, starting on day 2 of confinement
Confinement Benefits	
Newborn Care *For each day of confinement to a hospital for routine personal care following birth.*	$500 per day for 1 day per calendar year
Health Assesment/Wellness Benefit *Receive a cash benefit every year you and any of your covered family members complete a single covered exam, screening, or immunization.*	$50
Enhanced Benefits	
Hospital NICU Admissions *Increases the hospital ICU admission benefit for a newborn child's ICU or NICU admission by the percentage shown in the schedule of benefits.*	25%
Hospital NICU Confinement *Increases the hospital ICU confinement benefit for a newborn child's ICU or NICU confinement by the percentage shown in the schedule of benefits.*	25%

To Obtain the Semi-Monthly Rate:

Take the amount listed from the benefit amount & your age range x 12 & divide by 24

To Obtain the Bi-Weekly Rate:

Take the amount listed from the benefit amount & your age range x 12 & divide by 26

Group Supplemental & Dependent Life and AD&D

Eligibility

All Active Full-Time Employees, working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. **Dependents are:**

- Your legal spouse who is not legally separated or divorced from you;
- Your legally-recognized domestic or civil union partner,
- Your unmarried financially dependent children birth to 26 years;
- A person may not have coverage as both an Employee and Dependent;
- Only one insured spouse may cover dependent children;

Benefit Amount

- **Employee:** Choose from a minimum of $10,000 to a maximum of $500,000 in $10,000 increments.
- **Spouse:** Choose from a minimum of $5,000, a maximum of $100,000 in $5,000 increments, not to exceed 50% of employee amount.
- **Child(ren):** $1,000 from birth to 6 months; 6 months to 26 years $1,000 to $10,000 in increments of $1,000

Guaranteed Issue*

- **Employee:** $200,000
- **Spouse:** $50,000
- **Child(ren):** $10,000

* Amounts over this will require Evidence of Insurability.

Contribution Requirements

Coverage is 100% Employee Paid.

Value-Added Services

Travel Assistance Services

Rates

See rate sheet on the following page.

AD&D Schedule

For Accidental Loss of	Amount Payable
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%

Benefit Reduction Due to Age

Age	Original Benefit Reduced To:
65	65%
70	40%
75	20%

Features

- Accelerated Death Benefit
- Air Bag Benefit
- COMA Benefit
- Conversion Privilege
- Day Care Benefit
- Education Benefit
- Exposure & Disappearance
- FMLA/MSLA Extension
- Portability
- Total Loss of Use Benefit
- Seat Belt Benefit

Group Supplemental Life / AD&D Insurance

Employee life Insurance monthly rate		Spouse life insurance monthly rate	
Age Range	Premium Monthly Rate Per $1,000	Employee Age Range	Premium Monthly Rate Per $1,000
1-19	$0.040	1-19	$0.040
20-24	$0.040	20-24	$0.040
25-29	$0.040	25-29	$0.040
30-34	$0.040	30-34	$0.040
35-39	$0.050	35-39	$0.050
40-44	$0.080	40-44	$0.080
45-49	$0.120	45-49	$0.120
50-54	$0.200	50-54	$0.200
55-59	$0.300	55-59	$0.300
60-64	$0.400	60-64	$0.400
65-69	$0.640	65-69	$0.640
70-74	$1.450	70-74	$1.450
75-79	$3.660	75-79	$3.660
80-84	$8.360	80-84	$8.360
85-89	$8.360	85-89	$8.360
90-94	$8.360	90-94	$8.360
95-99	$8.360	95-99	$8.360
100+	$8.360	100+	$8.360

Dependent Child(ren) Monthly Premiums:	
BENEFIT AMOUNT	PREMIUM
$1,000	$0.15
$2,000	$0.30
$3,000	$0.45
$4,000	$0.60
$5,000	$0.75
$6,000	$0.90
$7,000	$1.05
$8,000	$1.20
$9,000	$1.35
$10,000	$1.50

One rate and benefit amount for all eligible children in family, regardless of number.

Glossary of Terms

Coinsurance: The percent of eligible changes that the plan pays after the calendar year deductible has been met.

EPO: A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency)

Deductible: The amount your pay each calendar year before the plan begins to pay for certain covered health care expenses.

Guaranteed Issue: The amount of coverage pre-approved by the insurance carrier regardless of health status.

Medical Emergency: A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.

Network Benefits: The benefits applicable for the covered services of a network provider.

Non-Network Benefits: The benefits applicable for the covered services of a non-network provider.

Open Enrollment: The period during which employees are given the opportunity to enroll or change their current coverage elections.

Out-of-Pocket Maximum: The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for the covered services for the remainder of the calendar year.

Plan Year: January 1, 2026- December 31,2026.

Preferred Provider Organization (PPO): A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a network or non-network provider, but network care is covered at a higher benefit level and the employee is responsible for a greater portion of the cost when using a non-network provider.

Usual and Customary Rates: Non-network health plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant.

Legal Notices

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 o f 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.

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 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:

Shannon Penney
5151 Headquarters Dr, Suite 220
Plano, Texas United States 75024
469-626-1722
spenney@drppg.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-forconsumers/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

Date:	January 1, 2026
Name of Entity/Sender:	Patient Physician Network Holding Co., LLC
Contact:	Director of Shared Services
Address:	5151 Headquarters Dr., Suite 220 Plano, Texas, United States 75024
Phone Number:	469-626-1722

Important Notice from Patient Physician Network Holding Co., 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 Patient Physician Network Holding Co., 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. Patient Physician Network Holding Co., LLC has determined that the prescription drug coverage offered by Evry Health 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:

- If otherwise eligible under the terms of the plan, you may stay in the Evry Health 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 Evry Health Plan creditable coverage.
- COBRA may be terminated when, after having elected COBRA continuation coverage, you enroll in Medicare. Otherwise, you may stay in the Evry Health Plans and also enroll in a Medicare prescription drug plan. The Evry Health Plans will be the secondary payer and Medicare Part D will become the primary payer.
- You may decline coverage in the Evry Health Plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do decide to join a Medicare drug plan and drop your current Evry Health Plan coverage, be aware that you and your dependents (if they elect to drop COBRA coverage as well) will not be able to get this coverage back.

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 Patient Physician Network Holding Co., 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 Patient Physician Network Holding Co., 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).

Date:	January 1, 2026
Name of Entity/Sender:	Patient Physician Network Holding Co., LLC
Contact:	Director of Shared Services
Address:	5151 Headquarters Dr., Suite 220, Plano, Texas, United States 75024
Phone Number:	469-626-1722

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA - Medicaid

Website: **http://myalhipp.com/**
Phone: 855-692-5447

ARKANSAS - Medicaid

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

ALASKA - Medicaid

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

CALIFORNIA - Medicaid

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

Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

KENTUCKY - Medicaid

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

FLORIDA - Medicaid

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

LOUISIANA - Medicaid

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

GEORGIA - Medicaid

GA HIPP Website: **https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp**
Phone: 678-564-1162 ext 2131
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/chil-drens-health-insurance-program-reauthorization-act-2009-chipra**

MAINE - Medicaid

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

INDIANA - Medicaid

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

MASSACHUSETTS - Medicaid and CHIP

Website: **https://www.mass.gov/info-details/masshealth-premium-assistance-pa**
Phone: 800-862-4840
Email: **masspremassistance@accenture.com**

IOWA - Medicaid and CHIP (Hawki)

Medicaid Website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid**
Phone: 800-338-8366
Hawki Website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki**
Hawki Phone: 800-257-8563
HIPP Website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**
HIPP Phone: 888-346-9562

MINNESOTA - Medicaid

Website: **https://mn.gov/dhs/health-care-coverage/**
Phone: 800-657-3672

KANSAS - Medicaid	MISSOURI - Medicaid
Website: **https://www.kancare.ks.gov/** Phone: 800-792-4884 HIPP Phone: 1-800-967-4660	Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
MONTANA - Medicaid	**OREGON - Medicaid and CHIP**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 800-699-9075
NEBRASKA - Medicaid	**PENNSYLVANIA - Medicaid and CHIP**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** Phone: 1-800-692-7462 CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx** HIP Phone: 1-800-986-KIDS (5437)
NEVADA - Medicaid	**RHODE ISLAND - Medicaid and CHIP**
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEW HAMPSHIRE - Medicaid	**SOUTH CAROLINA - Medicaid**
Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for HIPP program: 800-852-3345, ext 15218 Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**	Website: **https://www.scdhhs.gov** Phone: 888-549-0820
NEW JERSEY - Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/** Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 800-701-0710 (TTY: 711)	Website: **http://dss.sd.gov** Phone: 888-828-0059
NEW YORK - Medicaid	**TEXAS - Medicaid**
Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 800-541-2831	Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program** Phone: 800-440-0493
NORTH CAROLINA - Medicaid	**UTAH - Medicaid and CHIP**
Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100	Utah's Premium Partnership for Health Insurance (UPP) Website: **https://medicaid.utah.gov/upp/** Email: **upp@utah.gov** Phone: 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/**
NORTH DAKOTA - Medicaid	**VERMONT - Medicaid**
Website: **https://www.hhs.nd.gov/healthcare** Phone: 844-854-4825	Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Website: **https://dvha.vermont.gov/members/medicaid/hipp-program** Phone: 800-250-8427

OKLAHOMA - Medicaid and CHIP	VIRGINIA - Medicaid and CHIP
Website: **http://www.insureoklahoma.org** Phone: 888-365-3742	Medicaid Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** or **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid Phone: 800-432-5924 CHIP Phone: 855-242-8282 Email: **HIPPcustomerservice@dmas.virginia.gov**
WASHINGTON - Medicaid	**WISCONSIN - Medicaid and CHIP**
Website: **https://www.hca.wa.gov/** Phone: 800-562-3022	Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 800-362-3002
WEST VIRGINIA - Medicaid	**WYOMING - Medicaid**
Website: **http://mywvhipp.com/** Toll-free phone: 855-MyWVHIPP (855-699-8447)	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 307-251-1269

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)

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 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.

[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.

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/medicaidchip/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:

Date:	January 1, 2026
Name of Entity/Sender:	Patient Physician Network Holding Co., LLC
Contact:	Director of Shared Services
Address:	5151 Headquarters Dr., Suite 220, Plano, Texas, United States 75024
Phone Number:	469-626-1722

Thee 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 Patient Physician Network Holding Co., LLC	4. Employer Identification Number (EIN) 75-2718321	
5. Employer address 5151 Headquarters Drive, Suite 220	6. Employer phone number 626-1722	
7. City Plano	8. State Texas	9. ZIP code 75024
10. Who can we contact about employee health coverage at this job? Shannon Penney		
11. Phone number (if different from above) N/A	12. Email address spenney@drppg.com	

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

- As your employer, we offer a health plan to:

  [X] All employees. Eligible employees are:

  All active Full-time Employees, working 30 hours or more per week, except for any person working on a temporary or seasonal basis

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:

  Your legal spouse or domestic partner.
  Your dependent children from birth to 26 years.
  A person my not have coverage as both an Employee and Dependent

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended o 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 premium.

Patient Physician Network

The Leader in Advancing Independent Medicine