



2026 SSCP Full-Time Open Enrollment Guide

Important Contacts

COVERAGE	PHONE	WEBSITE
Medical & Prescription - BCBS PPO Group # 436693 HSA Group # 436694 HMO Group # 436695 Mobile App: BCBSTX Mobile App	800-810-BLUE (2583) Download on the App Store or Google Play	www.bcbstx.com
Medical & Prescription – Pan American Group Number: SE786 Mobile App: HealthiestYou	1-800-999-5382 Download on the App Store or Google Play	www.palig.com/us-providernetworks
Dental - BCBS Group Number: 436696 Mobile App: BCBSTX Mobile App	877-442-4207 Download on the App Store or Google Play	www.bcbstx.com
Vision - EyeMed Group Number: 9744517 Mobile App: EyeMed	866-268-4063 Download on the App Store or Google Play	www.eyemedvisioncare.com
Life and AD&D – Lincoln Life/ADD & Disability Group Number: 09- LF1210 HC/AI/CI Group Number: 1128909	800-790-7790 Email: FileClaim@LFG.com (ACC, CI, HI) Email: GroupLifeClaims@LFG.com (Life)	www.mylincolnportal.com(Life/Disability) www.Lincolnfinancial.com(ACC, CI, HI)
401k – Ameritas	800-745-9995	www.ameritas.com
WEX Benefits – Flexible Spending Accounts	866-451-3399	www.wexinc.com/discovery-
Employee Assistance Program (EAP) Mobile App: GuidanceNow	888-628-4824 Download on the App Store or Google Play	www.guidanceresources.com Username: LFGSupport Password: LFGSupport1

To review your current benefits please visit the online self-service benefit portal at:
<https://lfg.benselect.com/sscpmanagement>

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This guide highlights the main features of many of the benefit plans sponsored by SSCP Management. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. SSCP Management reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

GETTING STARTED

Welcome to Your 2026 BeneFITs!

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

This brochure highlights the main features of our employee benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. The Company reserves the right to change or discontinue its employee benefits plans at any time.

How to Enroll:

- **Enroll by November 14, 2025**
- Log in to: <https://lfg.benselect.com/sscpmanagement>; or
- Call the Enrollment Center:
1-866-503-6111

2026 OPEN ENROLLMENT

A lot of planning and care goes into offering the right benefits for you and your entire family. As we prepare for 2026, our benefit priorities remain unchanged: keep our plans competitive, cost-effective, and useful for you and your family, so you can thrive both personally and professionally.

This time of Open Enrollment gives you an opportunity to review your family needs and choose the benefits that are right for you. If you do not make your elections in <https://lfg.benselect.com/sscpmanagement> by **November 14, 2025**, you will not have benefits in 2026 unless you have a life event. Call 1-866-503-6111 or email openenrollment@sscpmanagement.com with any questions.

All Confirmed Coverages will begin on January 1, 2026.

New hires or Newly Full-time promoted employees will follow the Deadline noted in the offer letter.

Contact: openenrollment@sscpmanagement.com with questions.

Important Notice

If you enroll in medical coverage, you will be provided \$20,000 of Basic Life Insurance which requires that you designate a beneficiary.

*** Please visit <https://www.sscpbenefits.com> for all Mandatory Notices**

It is your responsibility to check your pay stubs to ensure that you are covering your premium costs. Failure to pay all or parts of your premium, may cause your coverage to be canceled whether you receive notice or not.

If you have questions, you may contact the enrollment center at 1-866-503-6111 or view your current year benefits before you start the enrollment process.

READ IT, REVIEW IT, SELECT IT, AND CONFIRM IT!

ACTION		HOW
Step 1	✓ Read your 2026 enrollment benefit guide.	Sent to you via PeopleMatter, or emailed to your restaurant location.
Step 2	✓ Review the plan comparison, the premiums, and your chosen provider's network to ensure they take the plan.	General details for each plan and Carrier Resources can be found at sscpbenefits.com .
Step 3	✓ Select the plans that fit your needs. ✓ Gather birthday and Social Security Number information for all dependents and beneficiaries. *All dependents must have a valid Social Security Number or TIN.	Login: https://lfg.benselect.com/sscpmanagement or call the Enrollment Center at 1-866-503-6111 to select the plans that fit your needs. Hours of Operation: 8:30 am – 5 pm CST; Monday – Friday <u>Extended Hours During Open Enrollment:</u> 8:30 a.m. – 7 p.m. CT on Nov. 4, Nov. 6, Nov. 11, and Nov. 13 (Tuesdays and Thursdays). They're also available on Saturday, Nov. 8 from 9 a.m. – 12 noon CT.
Step 4	✓ Confirm your choices by reviewing the confirmation page sent to your email address. ✓ Corrections made after your deadline are not guaranteed to take effect in 2026.	Confirmation reports will be sent to your email address within 24 hours of sign-off. *This is an important step to confirm you have finished the enrollment process*

Your Annual Enrollment elections, by law, will remain unless you have a qualifying mid-year change of life event. The list of qualified life events is governed by the IRS.

These event could include: change in legal marital status, change in number of dependents, or change in employment status that causes you, or your spouse or dependents to gain or lose benefits.

Selerix BeneFITs Enrollment Portal

We are proud to provide you with an online self-service benefit portal, and enroll-assisted option to facilitate your benefits enrollment.

You must login if you want to make any changes to your benefits for 2026. Medical, Dental, Vision, & FSA WILL NOT CARRYOVER.

Please visit: <https://lfg.benselect.com/sscpmanagement> to login. To access the site for the first time, please use the following credentials:

- **Username:** Enter your Social Security Number (*no dashes*)
- **PIN:** Enter the last four digits of your Social Security Number, plus the last two digits of your birth year (*i.e.* 678970)

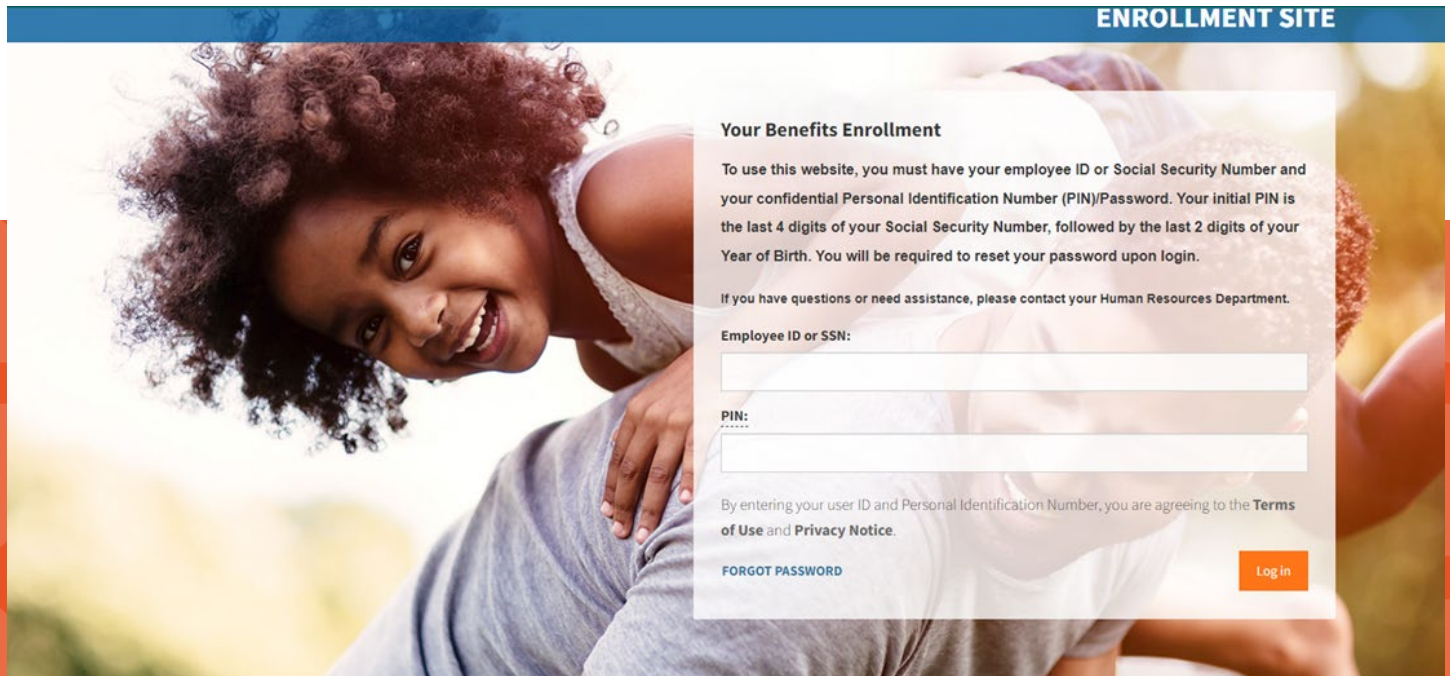
Benefit Counselors can be reached at 1-866-503-6111 between the hours of 8:30 a.m. through 5 p.m. CT, Monday through Friday. Please leave a voicemail if a benefits counselor is unavailable. You will receive a callback within 24 hours.

EXTENDED HOURS:

Nov. 4., Nov. 6, Nov. 11, and Nov. 13
(*all Tuesdays and Thursdays*)

8:30 a.m. – 7 p.m. CT

Saturday, Nov. 8
9 a.m. – 12 noon CT



ENROLLMENT SITE

Your Benefits Enrollment

To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN)/Password. Your initial PIN is the last 4 digits of your Social Security Number, followed by the last 2 digits of your Year of Birth. You will be required to reset your password upon login.

If you have questions or need assistance, please contact your Human Resources Department.

Employee ID or SSN:

PIN:

By entering your user ID and Personal Identification Number, you are agreeing to the [Terms of Use](#) and [Privacy Notice](#).

[FORGOT PASSWORD](#) [Log in](#)

Eligibility

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



After Enrollment

During the year, you cannot make changes to your benefits unless you have a qualified life event. If you do not make changes to your benefits within 30 days of the qualified life event, you will have to wait until the next annual open enrollment period to make changes (unless you experience another qualified life event). For newborn children, adoption, etc., you now have up to 60 days to add them to your plan.

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

BODY AND MIND

Medical Options - BlueCross BlueShield

	HSA \$6,350		PPO \$2,000		PPO \$1,000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE (Embedded)						
Individual	\$6,350	\$10,000	\$2,000	\$5,000	\$1,000	\$5,000
Family	\$12,700	\$20,000	\$4,000	\$10,000	\$2,000	\$10,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
Individual	\$6,350	\$20,000	\$6,500	\$10,000	\$6,500	\$10,000
Family	\$12,700	\$40,000	\$13,000	\$20,000	\$13,000	\$20,000
COINSURANCE/COPAYS						
Preventive Care	No charge	30% after deductible	No charge	50% after deductible	No charge	50% after deductible
Primary Care Physician	100% after deductible	30% after deductible	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Specialist	100% after deductible	30% after deductible	\$100 copay	50% after deductible	\$100 copay	50% after deductible
Lab/X-Ray	100% after deductible	30% after deductible	No charge	50% after deductible	No charge	50% after deductible
Complex Imaging (CT/PET scans/MRIs)	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Inpatient Care	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Surgery	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Chiropractic Visits	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Urgent Care	100% after deductible	30% after deductible	\$50 copay	50% after deductible	\$50 copay	50% after deductible
Emergency Room - Facility	100% after deductible	30% after deductible	\$250 + 80% after deductible		\$250 + 80% after deductible	
Durable Medical Equipment	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Inpatient Medical Equipment	100% after deductible	30% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Mental Health Services	100% after deductible	30% after deductible	No charge	50% after deductible	No charge	50% after deductible

COMPARING YOUR 2026 MEDICAL OPTIONS

When it comes to medical coverage, The company offers choices through BCBSTX and Pan American. You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs.

For more details on our 2026 benefit plans — how they work, what they cover, and what they cost — visit www.bcbstx.com or log in to <https://lfg.benselect.com/sscpmanagement>

PROVIDER FINDER

Visit www.bcbstx.com to log in or create an account on Blue Access for Members (BAM). Look for “Find Care” to:

- Find in-network providers, clinics, hospitals and pharmacies
- Search by specialty, zip code, language spoken, gender and more
- See clinical certifications and recognitions
- Compare quality, awards for doctors, hospitals and more
- Estimate the out-of-pocket costs for more than 1,700 health care procedures and tests
- Find cost-savings opportunities for prescription drugs

	BCBS HSA \$6,350	BCBS PPO \$2,000	BCBS PPO \$1,000
	After combined medical/ pharmacy deductible	After Pharmacy deductible \$250 Indv/\$500 Family	After Pharmacy deductible \$250 Indv/\$500 Family
PHARMACY -RETAIL (UP TO 30 DAY SUPPLY)			
Generic	\$0	\$0	\$0
Brand Name	\$0	\$50	\$50
Non-Preferred Brand	\$0	\$100	\$100
Specialty	\$0	\$250	\$250
MAIL ORDER RX (UP TO 90-DAY SUPPLY)			
Mail Order (Tier 1, 2, and 3)	\$0	\$0/\$125/\$250	\$0/\$125/\$250

Terms to Know

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).

- **Out-Of-Pocket Maximum (OOP Max):**
The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.
- **Embedded Deductible or OOP Max:** A single family member does not need to meet the family deductible or OOP max before the benefit begins to pay for healthcare services.

Medical Options - BlueCross BlueShield

TEXAS ONLY

HMO \$2,500		
IN-NETWORK		OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE (EMBEDDED)		
Individual	\$2,500	N/A
Family	\$5,000	N/A
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
Individual	\$6,600	N/A
Family	\$13,200	N/A
COINSURANCE/COPAYS		
Preventive Care	100% after	N/A
Primary Care Physician	\$25 copay	N/A
Specialist	\$75 copay	N/A
Lab/X-Ray	80% after ded	N/A
Complex Imaging (CT/PET scans/MRIs)	80% after ded	N/A
Inpatient Care	80% after ded	N/A
Outpatient Surgery	80% after ded	N/A
Chiropractic Visits	\$25/\$75 copay	N/A
Urgent Care	\$100 copay	N/A
Emergency Room - Facility	\$500 + 80% after deductible	
Durable Medical Equipment	80% after deductible	N/A
Inpatient Medical Equipment	80% after deductible	N/A
Outpatient Mental Health Services	\$25 copay	N/A

BCBS HMO \$2,500	
After combined medical/pharmacy deductible	
RETAIL PRESCRIPTIONS (UP TO 30-DAY SUPPLY)	
Generic	\$20
Brand Name	\$50
Non-Preferred Brand	\$85
Specialty	\$250
MAIL ORDER RX (UP TO 90-DAY SUPPLY) for Brand & Non-Preferred	
Mail Order (Tier 1, 2, and 3	\$50/\$125/\$212.50



Pan American

	Plan 1	Plan 2
INPATIENT HOSPITAL		
Hospital admission benefit - overall	\$1,000	\$1,000
Room and board benefit per day (if different from below)	\$100	\$300
Total days covered	60	60
Mental/nervous benefit per day	\$50	\$150
Mental/nervous days covered	60	60
Substance abuse benefit per day	\$50	\$150
Substance abuse days covered	30	30
Intensive care benefit per day	\$200	\$600
Intensive care days covered	30	30
Skilled nursing facility benefit per day	\$50	\$150
Skilled nursing facility days covered	57	57
Inpatient surgery per procedure (1 day per calendar year)	\$500	\$1,000
Maximum anesthesia benefit (1 day per calendar year)	\$125	\$250
OUTPATIENT HOSPITAL		
Outpatient surgery benefit per day (1 day per calendar year)	\$250	\$500
Maximum anesthesia benefit (1 day per calendar year)	\$62.50	\$125
Diagnostic labs benefit per day	\$35	\$45
Diagnostic labs days covered	3	3
Diagnostic radiology benefit per day	\$70	30% after deductible
Diagnostic radiology days covered	4	2
Diagnostic advanced studies	\$300	\$400
DOCTOR'S OFFICE VISITS		
Doctor's office benefit per service - all	\$75	\$75
Visits allowed per year	4	6
PRESCRIPTION DRUGS		
Generic copay per 30-day script	Discount only	\$10
Formulary brand copay per 30-day script	Discount only	\$40
Non-formulary brand copay per 30-day script	Discount only	\$75
Formulary brand copay per 30-day script	N/A	\$1,000
OTHER BENEFITS		
Telemedicine	Included/\$0 copay	Included/\$0 copay

This is a fixed indemnity policy, NOT health insurance. This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

Prescription Drug Coverage - Pan American: If you enroll in the Pan American plan, prescription drug coverage is provided through the RxEDO Pharmacy Network. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order programs.

Telemedicine

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

REGISTER TODAY SO YOU ARE READY WHEN YOU NEED CARE



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



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



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



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



Avoid costly copays and deductibles associated with the emergency room and urgent care clinics.

USING TELEMEDICINE IS AS EASY AS ONE, TWO, THREE

- 1. Register Now**
Setting up your secure account takes only minutes.

BCBS Mobile App:

MDLIVE

Pan American Mobile App:

HealthiestYou



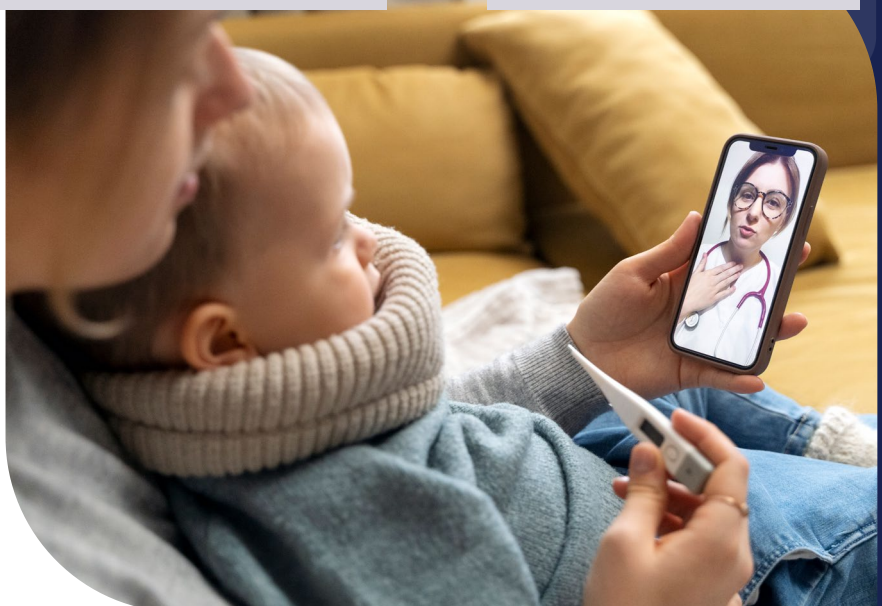
- 2. Request a Visit**
You can have a doctor visit right away or schedule an appointment all by phone or computer



- 3. Feel Better**
Get treated by one of our doctors who can prescribe medication if necessary.

BCBS 24/7 NURSELINE

Registered nurses are available 24 hours a day, seven days a week to answer your health questions and help you decide the best methods of care. You can contact the 24/7 Nurseline for you and your covered family members. Call 800-581-0393 to reach the 24/7 Nurseline anytime.



Well onTarget – BCBS

Well onTarget, administered by BCBSTX, is designed to give you the support you need to make healthy lifestyle choices — and reward you for your hard work.

MEMBER WELLNESS PORTAL

The Well onTarget Wellness Portal uses the latest technology to give you the tools you need for better health. Your wellness journey begins with a suggested list of activities based on the information you provided in the Health Assessment. The suite of programs and tools include:

- **Digital self-management programs:** Learn about nutrition, fitness, weight loss, quitting smoking, managing stress and more!
- **Health and wellness library:** The health library has useful articles, podcasts and videos on health topics that are important to you.
- **Blue Points program:** Earn points for wellness activities to redeem for a gift for yourself or someone else.
- **Tools and trackers:** These interactive resources help keep you on track while making wellness fun.
- **Health assessment:** Answer some questions to learn more about your health and receive a personal wellness report.
- **Fitness and nutrition tracking:** Get Blue Points for tracking activity with popular devices and mobile apps.
- **Personal challenges:** Join a personal challenge to help you reach your goals. There are over 30 challenges, so you can choose the best one to fit your wellness journey. Topics include stress, sleep, physical activity and more!

How to Access the Portal:

Use your
Blue Access for Members (BAM) account:

- Log in to BAM at bcbstx.com/member. If this is your first time logging in, you will need to register your account. Click “**Create an Account**” on the login screen.
- Once you are in BAM, click on the “**My Health**” tab, then “**Wellness**.” Click on “**Visit Well onTarget**” and you will be taken to the portal.

QUESTIONS?

If you have questions about Well onTarget, call BCBSTX customer service at 877-806-9380.



Dental- BCBS

With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. You have two dental plan options through BCBS to choose from. Both plans provide you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

High PPO Plan offers a higher annual benefit maximum and greater coverage for basic and major dental services. Preventive services, including routine exams, cleanings, and fluoride treatments are covered at 100%. This plan's \$1,500 annual benefit maximum and orthodontia coverage provide a more encompassing benefit that could better fit your dental needs.

Low PPO Plan allows you the freedom to visit any dentist, without referrals, for all your dental care. If you receive care from one of BCBS preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims.

For a list of BCBS preferred dentists, go to www.bcbstx.com.

PLAN FEATURE	HIGH PPO PLAN	LOW PPO PLAN
CALENDAR YEAR PLAN MAX		
Individual	\$50	\$50
Family	\$100	\$100
ANNUAL MAXIMUM		
Annual Benefit Maximum	\$1,500 Does not apply to preventive services	\$750
PREVENTIVE SERVICES		
Exams, routine cleanings, fluoride treatments, space maintainers	100%	100%
BASIC SERVICES		
X-rays, fillings, sealants, denture repairs	80% after deductible	50% after deductible
MAJOR SERVICES		
Crowns, inlays, onlays, bridges, dentures	50% after deductible	30% after deductible
ORTHODONTIA		
For dependent children up to age 19	50% after deductible \$2,000 Lifetime Max	N/A

3-Month Deductible Carryover: If you are enrolled in dental and meet your deductible between October through December of the plan year, you will not need to meet it again in the following (calendar) year.

Vision – Eyemed

Healthy eyes and clear vision are an important part of your overall health and quality of life. The company offers a vision plan to help you cover the cost of routine vision services and supplies, like eye exams, eyeglasses, and contact lenses. This plan gives you the flexibility to choose between in-network and out-of-network providers each time you need vision care. To find a in-network provider visit www.eyemedvisioncare.com.

EyeMed’s network includes a number of retail chain locations (such as Pearle Vision, EyeMasters, etc.), as well as some private-practice providers. This table summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

VISION PLAN		
	IN-NETWORK	OUT-OF-NETWORK
	YOU PAY	REIMBURSEMENT
Exam	\$10	Reimburse up to \$35
Materials copay		
Single vision lenses	\$25	Reimburse up to \$25
Bifocal lenses	\$25	Reimburse up to \$40
Trifocal lenses	\$25	Reimburse up to \$60
Lenticular lenses	20% off retail price	Not covered
Frames	\$120 allowance plus 20% of any amount over	Reimburse up to \$48
Necessary contacts in lieu of frames/lenses	\$0 copay	Reimburse up to \$200
Elective contacts	\$135 allowance	Reimburse up to \$95
Benefit Frequency		
Exams	Every 12 months	Every 12 months
Lenses	Every 12 months	Every 12 months
Frames	Every 12 months	Every 12 months
Contacts	Every 12 months	Every 12 months



Employee Assistance Program (EAP)

Available to all employees and your eligible family members, our EAP, administered by Lincoln Financial, provides free access to licensed counselors whether or not you elect other benefits coverage. Through this coverage, you and your families receive immediate support and guidance and assessments and referrals for further services. Your benefits include up to five face-to-face visits per new issue per year. You can contact the EAP for help with the following:

Licensed counselors can help with issues such as:



Mental health concerns



Emotional difficulties



Domestic abuse



Substance abuse



Financial worries



Grief and loss



Relationship support



Self-esteem and personal development



Stress management



Work-life balance

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

Call 888-628-4824, 24 hours a day, 7 days a week, to talk with a professional counselor.

You may also visit www.guidanceresources.com and enter the following credentials:

Username: LFGSupport

Password: LFGSupport1



FUNDING ACCOUNTS

Flexible Spending Accounts (FSA)

FSAs allow you to pay for eligible expenses using tax-free dollars. Important: There is a “use it or lose it” rule imposed by the IRS. If you do not spend all the money in your Health Care, Limited Purpose, or Dependent Care FSA by March 15th of the following year for expenses incurred from January 1 – December 31, unused dollars will be forfeited per IRS regulations for pretax contributions. The FSA program is administered by WEX.

HOW FSAS WORK

Two types of FSAs are available to you: Health Care FSA and Dependent Care FSA. If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks pre-tax and deposited into your account throughout the year. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself. The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. If you enroll in the High Deductible Health Plans (HDHPs), you cannot enroll in the Health Care FSA.

HEALTH CARE FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by dental plan

Looking for eligible products or services?

Visit <https://www.wexinc.com/resources/benefits-toolkit/eligible-expenses/>.

USE IT OR LOSE

With both accounts, the IRS requires you to use all the money in your account by the end of the year or you lose it. This is called the “use it or lose it” rule.

ANNUAL CONTRIBUTION AMOUNT

You can contribute up to \$3,400 per year to the Health Care FSA. PLEASE NOTE: Annual limits budget subject to change by IRS.

This account is available to all eligible employees who are not enrolled in the BCBS HSA plan.

If you and your spouse are both offered FSA plans, you can each elect the maximum for a combined household set aside of \$6,800.

You must use your FSA contributions each year or you lose value. However, this plan has a grace period, which allow you to continue to use FSA funds for 2½ months into the next year to use before March 15, 2026.

Your FSA Debit Card, from WEX will be loaded with the total value of your FSA election on January 1, 2026.

HEALTH CARE FSA DEBIT CARD

To participate in an FSA for 2026, you must enroll. New Health Care FSA participants will receive a debit card allowing you to pay for eligible expenses directly with funds in your account —no claim forms needed! (*Current FSA participants keep their debit cards to use in the new year*). If you enroll in an FSA, be sure to save your FSA receipts in case the IRS asks for documents verifying your eligible expenses.

FSA STORE

Visit www.FSAstore.com for eligible FSA products and services. You can use your pre-tax money to save on a variety of everyday items (*Band-aids, baby products, Tylenol, and cough drops*), to more complex items and services (*diabetes, blood pressure monitors, online therapy, CPAP machines, eyeglasses, muscle and body pain relief systems and more*).

DEPENDENT CARE FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- You can set aside from \$100 to \$7,500 per year.
- If you are married and you and your spouse file separate tax returns, the maximum you can contribute is \$3,750 each.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled, and unable to provide care for themselves.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

USE IT OR LOSE

With both accounts, the IRS requires you to use all the money in your account by the end of the year or you lose it. This is called the “use it or lose it” rule.

ELIGIBLE DEPENDENT CARE EXPENSES

Generally, you may use the money in your Dependent Care FSA for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (*spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home*).

Typical expenses eligible for reimbursement under the plan include:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents.
- Services from a care provider over the age of 19 (*inside or outside the home*).
- Day camps
- After-school care

For a complete list of eligible expenses, visit <https://www.wexinc.com/resources/benefits-toolkit/eligible-expenses/>.

LEGAL PROTECTION

Life and AD&D

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiaries to help meet expenses in the event of your death or in the case of a covered accidental injury. You may choose from two Life and AD&D plans, both administered by Lincoln Financial. One plan is company provided and the other is the voluntary plan we continue to offer.

BASIC EMPLOYEE TERM LIFE AND AD&D INSURANCE

We automatically provide Basic Life and AD&D Insurance at no cost for all employees who elect a medical plan. Basic Life and AD&D Insurance is equal to a flat \$20,000. The benefit is paid to your beneficiaries in the event of your death. There is an SSCP-paid flat rate of \$20,000 covered for you for basic life and AD&D insurance.

COVERAGE AFTER AGE 65

If you remain an active employee after reaching age 65, the total amount of your basic and supplemental employee coverage will begin to decrease: When you reach age 65, coverage will be reduced by 35%. When you reach age 70, coverage will be reduced by 50% of the coverage in place.

BENEFICIARY INFORMATION

To ensure your family's financial security, keep your beneficiary information up-to-date. Be sure to designate a beneficiary through the enrollment site <https://lfg.benselect.com/sscpmanagement>. You must choose at least one beneficiary for each plan, however, you can update or change your beneficiary at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY (EOI)

Lincoln will require you to provide EOI before approving any new or additional coverage you elect during open enrollment. Guaranteed Issue coverage for you, the employee, are up to \$180,000, and up to \$30,000 for your spouse, and up to \$10,000 for dependent children.

SPOUSE AND CHILD TERM LIFE INSURANCE

You may purchase coverage for your spouse in increments of \$5,000 to \$250,000, not exceeding 100% of your optional term life coverage amount. Guaranteed Issue amount is \$30,000. You may also purchase coverage for your dependent children in increments of \$2,000 to \$10,000. Guaranteed Issue coverage for a child from birth to 14 days is \$500.

SUPPLEMENTAL EMPLOYEE TERM LIFE AND AD&D INSURANCE

You can also elect additional coverage in \$10,000 increments up to \$500,000 (rounded to the next higher \$1,000), subject to certain limits. If you elect voluntary life and AD&D insurance for yourself, there's an employee-paid rate of increments of \$10,000, not to exceed five times your salary, up to \$500,000.



Disability Insurance

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. Disability Insurance is administered by Lincoln Financial. Please note: if you do not elect disability insurance when you are first eligible, you will be required to submit EOI before coverage can begin.

SHORT-TERM DISABILITY (STD)

You pay 100% of the STD premium, and your STD benefits will replace 60% of your base pay for 13 weeks. After you have used your illness days, your STD benefits begin on the 15th calendar day of your disability if you are unable to work. The maximum benefit available is 13 weeks, up to a maximum weekly benefit of \$1,500 per STD claim. *New hire enrolling in this coverage during open enrollment will not require EOI.

LONG-TERM DISABILITY (LTD)

If you remain totally disabled and unable to work for more than three months, you may be eligible for LTD benefits. We offer you LTD benefits that replace up to 60% of your base pay, up to a maximum of \$6,000 per month. You pay 100% of the premium. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation). There is an exclusion for conditions in which you have been previously treated within the last 12 months.



Hospital Indemnity, Critical Illness, and Accidental Injury Insurance

Administered by Lincoln Financial, Hospital Indemnity, Critical Illness, and/or Accidental Injury insurance, you will receive payments if you need treatment or to pay for a qualified expense not covered by traditional insurance.

Lincoln will pay you for hospital stays, for treatments of injuries resulting from a covered accident, or for expenses such as rehabilitation, and out-of-pocket expenses when a covered person is diagnosed with a critical illness or specified event occurs.

Medical Bill Saver

Skilled negotiators work with your healthcare providers to help lower out-of-pocket costs on unpaid medical and dental bills over \$400 that are not covered by insurance. You may receive help with:

- Reducing claim costs, complaints, and appeals
- Understanding covered versus non-covered services
- Getting provider sign-off for payment terms and conditions

Personal Concierge Services

- Contact highly qualified professionals who can help you handle a wide range of personal tasks, including:
- Travel arrangements, including flights, lodging, and dining reservations
- Tickets for sporting, concerts and other entertainment events
- Event planning



Download the Health Advocate app from the Apple App Store, and the Google Play Store.

401(k) Retirement Plan

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan, administered by Ameritas, allows you to save for retirement on a pre-tax basis. You can make traditional (pre-tax) and/or Roth (after-tax) contributions. Your deferral amounts may be modified monthly, and you may stop deferrals at any time.

Qualified employees are required to opt-in by completing an Election Change Request anytime throughout the year. **We will match \$0.50 for every \$1.00 that you contribute to the plan, up to the first \$1,500 each year (The match will not exceed \$750 per year).** Beneficiaries can also be updated at any time. (Highly Compensated Employees in accordance with yearly IRS rules are ineligible to participate in the 401(k) plan. Speak with HR if you have questions about your eligibility).

INVESTMENT OPTIONS

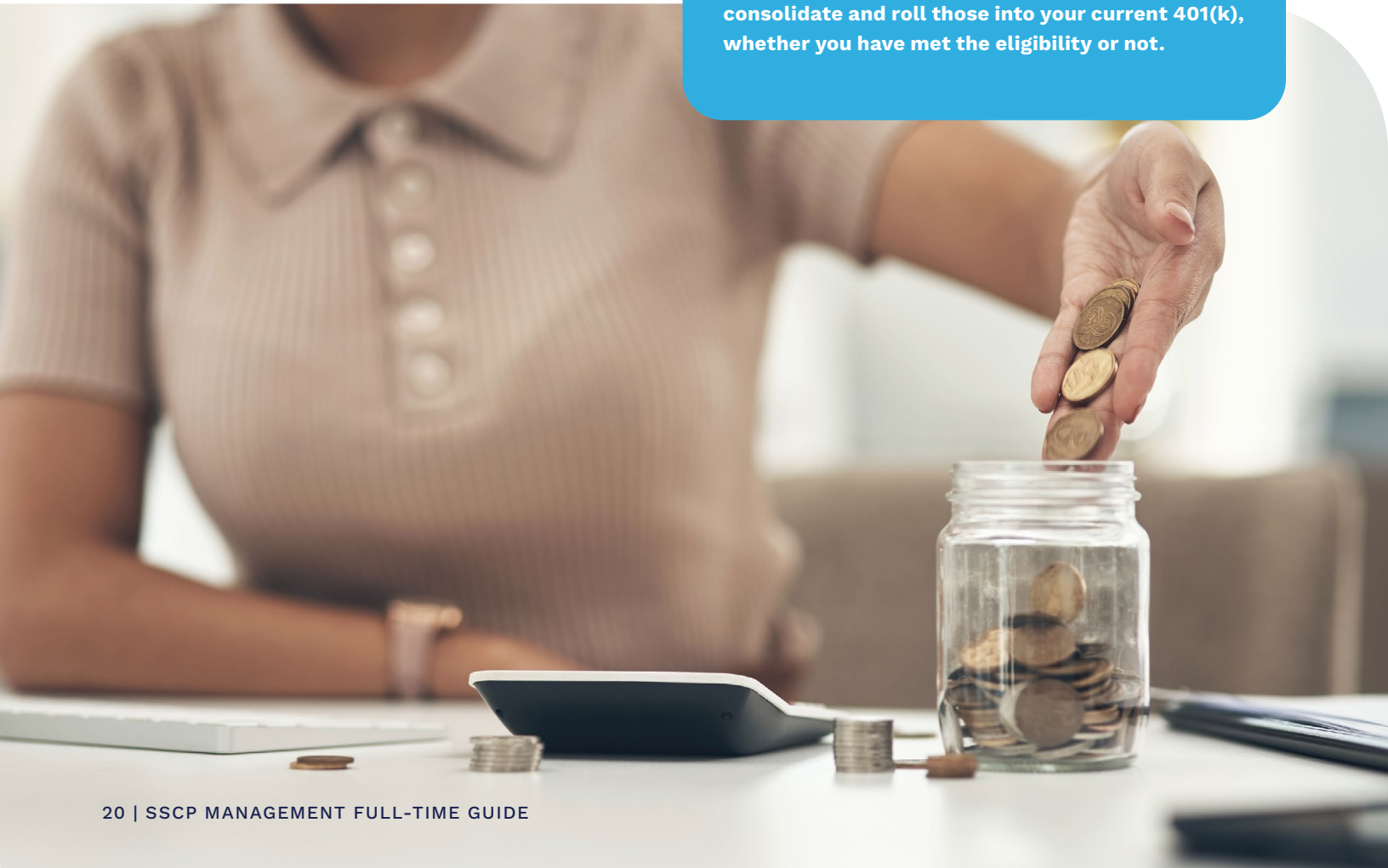
The 401(k) Plan offers several investment options covering a broad range of risk. A prospectus brochure including fund performances are available at any time. For more information about your 401(k) plan visit www.Ameritas.com.

First time users will need to register using the Certification code mailed to the address of record during their new hire window.

If you are AGE 50+ you can make an additional contribution of \$7,500, totaling \$31,000 per year. In 2026, workers ages 60-63 can boost annual 401(k) catch-up contribution to \$10,000 or 150% of catch-up limit - whichever is greater.

Rollover Options

Employees who have previous retirement plans (401(k), 403(b), IRAs, etc.) are eligible to consolidate and roll those into your current 401(k), whether you have met the eligibility or not.



Pet Insurance

Pets play a huge role in our lives. To help take the worry out of covering costs for your pet's health care, My Pet Protection Choice, administered by Nationwide, allows you to enroll your furry friends at any time throughout the year. Plans are available featuring several reimbursement options (50%, 70%, and 80%), so you can find coverage that fits your budget. My Pet Protection Choice includes coverage for accidents, illnesses, injuries, wellness and more.

1. Visit: <https://benefits.petinsurance.com/sscpmanagement>
2. Call 877-738-7874 and mention SSCP Management to receive preferred pricing
3. Visit [My Pet Protection Choice](#) for additional information, including flyers and videos.



Paycheck Deductions

The amounts listed below are the rates per pay period.

MEDICAL	BCBS HSA \$6,350	BCBS PPO \$2,000	BCBS PPO \$1,000	BCBS HMO PLAN (TEXAS ONLY)
Employee Only	\$57.99	\$228.58	\$270.45	\$185.48
Employee + 1	\$289.10	\$455.67	\$550.65	\$370.10
Employee + Family	\$437.35	\$704.33	\$849.05	\$610.78
Pan American	Plan 1	Plan 2		
Employee Only	\$17.80	\$46.26		
Employee + 1	\$34.17	\$88.69		
Employee + Family	\$55.92	\$135.53		

DENTAL	HIGH PPO	LOW PPO
Employee Only	\$17.07	\$9.80
Employee + Spouse	\$34.71	\$19.85
Employee + Family	\$55.44	\$29.91

EYEMED VISION	
Employee Only	\$2.38
Employee + Spouse	\$4.52
Employee + Family	\$6.65

To view additional contributions for the group Hospital, Accident, and Critical Illness benefits, please log onto <https://lfg.benselect.com/sscpmanagement>. Visit the Forms Library in the enrollment portal for plan summaries, educational videos, and mandatory notices. It is important that you understand what your benefit options cover and what it may not cover.

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 –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584

Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HSHIPPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742

Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002

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
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, ext. 61565

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

9.96%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 9.96% of the employee’s household income.^{1,2}

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 of 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. 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](https://www.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 [healthcare.gov/medicaid-chip/getting-medicaid-chip](https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip) for more details.

How Can I Get More Information?

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

Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see [irs.gov/pub/irs-drop/rp-22-34.pdf](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% 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.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

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

Example: When you were hired, you were single and

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: SSCP HR Department at 972-644-9494 x106.

Important Notice from SSCP Management 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 SSCP Management 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. SSCP Management has determined that the prescription drug coverage offered by the SSCP Management 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 15 to December 7.

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 SSCP Management coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current SSCP Management coverage, be aware that you and your dependents may 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 SSCP Management 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 SSCP Management 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: 01/01/2026

Name of Entity/Sender: SSCP Management

Contact-Position/Office: HR Department

Address: 13355 Noel Road Suite 1645 Dallas, TX 75240

Phone Number: 972-644-9494 x106

Important Information: COBRA Continuation Coverage and other Health Coverage Alternatives

This notice has important information about your right to continue your health care coverage in the SSCP Management (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

Why am I getting this notice?

You're getting this notice because you are enrolled in the Plan or eligible for enrollment in the Plan.

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the following categories can elect COBRA continuation coverage

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage

- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>.

How much does COBRA continuation coverage cost?

Other coverage options may cost less. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your

COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period¹ to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA

continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar

• **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact SSCP Management Human Resources.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at <http://www.dol.gov/ebsa> or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

1. <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>. These rules are different for people with End Stage Renal Disease (ESRD).

Michelle's Law Enrollment Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the SSCP Management group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your

dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of SSCP Management group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the SSCP Management group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the SSCP Management group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The SSCP Management group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

To obtain additional information, please contact: Human Resources.

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

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

Therefore, the following deductibles and coinsurance apply: PPO 1000 \$1,000 deductible, 20% coinsurance, PPO 2000 \$2,000 deductible, 20% coinsurance, HSA 6350 \$6,350 deductible, 0% coinsurance, HMO 2500 \$2,500 deductible, 20% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator at SSCP Human Resources.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at SSCP Human Resources for more information.

Patient Protection Notice

SSCP HMO health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, SSCP HMO health plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from SSCP HMO health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier.



SSCP

