

2026 - 2027

EMPLOYEE BENEFITS GUIDE

September 1, 2026 - August 31, 2027

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CONTACT INFORMATION

DIRECTORY

For any questions or concerns you may have regarding your 2026-2027 Employee Benefits, you can contact the following:

- For claims assistance, you can contact the insurance carrier. You will need your ID number or Social Security number, date of service and provider name.
- For additional assistance or questions, please contact one of our Benefit Counselors at the Benefits Service Center.

Before you speak with a Benefit Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Benefits Service Center (*Consejeros que hablan español están disponibles.)			
Monday - Friday: 8:00 am - 7:00 pm CST		(866) 409-3174 https://uplift.benevibe.co/	
Benefit/Carrier	Policy/Group #	Telephone/Website or Email	Where to File Claims
Medical Cigna OAP In - High Deductible OAP In - Low Deductible OAP HDHP HSA Eligible OAP Grandfathered (Closed)	00659353	(866) 494-2111 www.cigna.com	Online - MyCigna (registration required) Cigna Pre-Authorization Form Cigna Medical Claim Form (English) Cigna Medical Claim Form (Spanish) Cigna Pharmacy Claim Form
Emergency Medical Transportation MASA	B2BUPEDU	(877) 503-0585 www.msaaccess.com	
Health Savings Account Flexible Spending Accounts CAS	N/A	(877) 941-5956 www.consolidatedadmin.com	Online – CAS Website (registration required) Medical Claim Form Dependent Care Claim Form
Dental Cigna Low Plan High Plan	0659353	(800) 244-6224 www.cigna.com	Online: MyCigna (registration required) Dental Claim Form (English) Dental Claim Form (Spanish)
Vision Cigna	0659353	(888) 353-2653 www.cigna.com	Online: MyCigna (registration required) Vision Out-Of-Network Claim Form (English) Vision Out-Of-Network Claim Form (Spanish)
Short Term Disability Long Term Disability Basic Life and AD&D Voluntary Life and AD&D Accident Critical Illness Hospital Indemnity Voya	755541	(833) 973-2367 www.voya.com	Disability Claim Forms Accidental Death and Dismemberment Claim Form Accident Claim Form Critical Illness Claim Form Hospital Indemnity Claim Form
Universal Life Transamerica Life Insurance	G000046991	(800) 797-2643 www.transamerica.com	Online - Transamerica Universal Life (Registration required) Death Claim Form
Cancer Insurance Guardian	551834	(800) 268-2525 www.guardiananytime.com	Guardian Forms and Claims
403(b) Retirement Benefit TCG Group Holdings	N/A	(800) 943-9179 www.region10rams.org 403b@tcgservices.com	N/A
Employee Assistance Program Voya	755541	(833) 303-3750 (919) 341-7440 one.telushealth.com Username: Voya Password: eap	N/A
Pet Insurance Nationwide	13112	(877) 738-7874 partnersolutions.nationwide.com/pet/uplifteducation	N/A
Uplift Talent Management Uplift Education	N/A	iHelp Tickets	Uplink Home

WELCOME

To Your Employee Benefits

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Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **September 1, 2026 to August 31, 2027** plan year. Please read this Benefits Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

Uplift Education will be utilizing Professional Enrollment Concepts' (PEC) services for our benefit communication and enrollment this year. PEC's Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

ABOUT THIS BENEFITS GUIDEBOOK

This Benefits Guidebook describes the highlights of Uplift Education's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this Benefits Guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Uplift Education's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Uplift Education.

WHAT'S NEW THIS 2026-2027 YEAR?

- The annual contribution limit for **Health Savings Accounts** increased from \$4,300 to \$4,400 per plan year for employees enrolled in Employee Only medical coverage and from \$8,550 to \$8,750 per plan year for employees enrolled Employee & Children, Spouse, or Family coverage.
- The cafeteria credit will no longer be provided for those who waived medical.
- The annual contribution limit for the **Health Care FSA** plan increased from \$3,300 to \$3,400 per plan year.
- **New Carrier!** Voya will now be the new carrier for EAP, Basic Life AD&D, Voluntary Life AD&D, Short Term Disability, Long Term Disability, Accident, Critical Illness and Hospital Indemnity.
 - EAP and Hospital Indemnity. **New and Improved Plan!**
- **Digital Cigna ID cards available online on September 1st, 2026.**
- **403(b)** max contribution amount increased from \$23,500 to \$24,500.

ELIGIBILITY

PART-TIME EMPLOYEES

Employees working at least 10 hours but less than 30 hours per week, are eligible for medical insurance, pet insurance, and MASA medical transportation benefits. Part-time employees enrolled in medical coverage are responsible for 100% of the monthly premium and do not qualify for the employer contribution toward the cost of coverage.

EMPLOYEE ELIGIBILITY

New Hires have 30 days from their hire date to enroll in or decline benefits. All benefits are effective the first of the month following your hire date.

Ancillary Benefits:

- Accident Insurance
- Critical Illness Insurance
- Cancer Insurance
- Dental Insurance
- Hospital Indemnity Insurance
- Short-Term Disability Insurance
- Supplemental Life Insurance
- Universal Life Insurance
- Vision Insurance
- Long-Term Disability Insurance
- MASA Medical Transportation
- Pet Insurance

DEPENDENT ELIGIBILITY

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the Uplift insurance and healthcare benefits programs. Uplift Education may conduct an audit requesting supporting documentation on all eligible dependents at any time during the plan year. Eligible dependents include one or more of the following:

- Your spouse;
- A child under the age of 26;
- A child of any age who is certified as disabled and dependent on the parent for support and maintenance.



ENROLLMENT INSTRUCTIONS

HOW TO ENROLL

**Avoid making quick decisions - enroll early!*

This year you have **two enrollment options**. You can contact our **Benefit Counselors at the Benefits Service Center** or utilize our **online self-service platform to explore your options further and complete your benefits enrollment process**.

To complete your enrollment process, please have the following information ready: dependents' names, beneficiaries, birth dates, social security numbers, addresses, and phone numbers.

Call Center Enrollment

Benefits Service Center*: (866) 409-3174
Monday - Friday: 8:00 AM - 7:00 PM (CST)

**Consejeros que hablan español están disponibles.*

Online Enrollment

Online Enrollment Website:

transamerica.benselect.com/enroll

For online enrollment, use the following format as login information:

Employee ID or SSN: Your SSN with no formatting (#####)

PIN: Last 4 digits of your SSN and the last 2 digits of your birth year (#####)

Example:

John Smith | SSN: 123-45-6789 | DOB: 01-27-1993

Employee ID or SSN: 123456789

PIN: 678993

Visit [page 6](#) for more detailed self-serve instructions.

BENEFITS EFFECTIVE DATE

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE), visit pg 8 for more information.

- **New Hires:** Your coverage begins the first of the month following your date of hire, for more information visit page 7.
- **Current Employees:** Any changes you make during the annual open enrollment period will become effective on September 1.

The benefits plan year is **September 1 through August 31**.



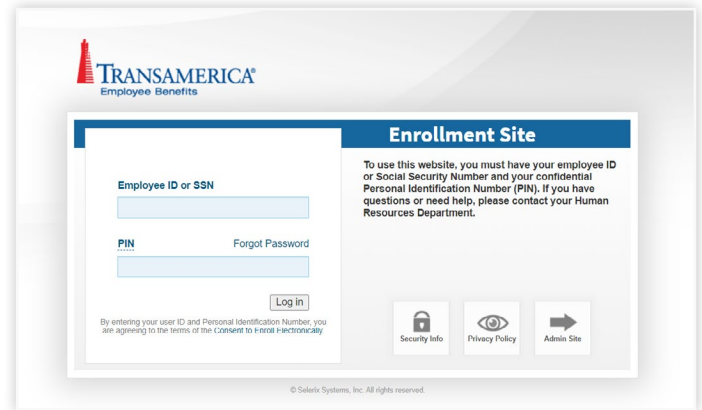
2026 OPEN ENROLLMENT

Enrollment is strongly encouraged, whether you choose to elect or waive coverage. Remember you must enroll each year in your Flexible Spending Account.

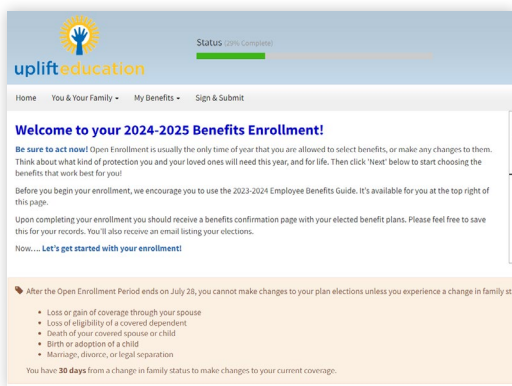
OE runs from **July 6, 2026 - July 31, 2026**.

SELF-SERVICE INSTRUCTIONS

- Register for the portal by logging on to: transamerica.benselect.com/enroll
Employee ID or SSN: Your SSN with no formatting (#####-####)
PIN: Last 4 digits of your SSN and the last 2 digits of your birth year (#####)



- Review the Welcome screen for important plan information. When ready **click Next** to continue.
- Next, you will be asked to enter dependent information. To add a dependent, **click the + sign** and enter the dependent’s information. To edit an existing dependent, **click the pencil icon** on the right side of the dependent. After making any changes, **click save** on the bottom of the page. Once you are finished with this section, **click next**.
- Once you are at the medical screen, verify your medical plan election or waive the coverage. When you **click next**, you will advance to any coverage that you have not previously enrolled in.
- Once you are at the medical screen, verify your medical plan election or decline the coverage. When you **click next**, you will advance to any coverage that you have not previously enrolled in.



- If you would like to make changes to existing coverage, you may click on the individual coverage options listed under **“My Benefits”** or by choosing the coverage under the **“My Benefits” menu** at the top of the screen.
- Once you select the coverage you would like to change, click on **“Unlock”** to access the options. Once you make a decision, **click next** to go to the review page.
- Once on the **“Sign and Submit”** page, you will be able to review your elections. If you need to make changes, click on the link for that coverage. You will then unlock, make your change, and **click next**. This returns you to the **“Sign and Submit”** page. If everything is correct, **click next**.

- On the **“Confirmation”** page, enter your PIN / Password used to log in. **This will finalize your enrollment.** You can print the confirmation form, save it as a downloadable PDF, and e-mail a confirmation summary to the e-mail address on file.

If you have any additional questions regarding your benefits, please call:

Benefits Service Center: (866) 409-3174
Monday - Friday: 8:00 AM - 7:00 PM CST

NEW HIRE CHECKLIST

Welcome to the Uplift Family! We are honored to offer a competitive benefits package designed to meet the needs of you and your family. You have thirty days from your date of hire (printed on your offer letter) to complete your New Hire Enrollment elections.

Whether this is your first time accepting benefits from an employer or your 10th, there are many things to consider prior to and after enrollment. We have created the following checklist of tasks to guide you through the enrollment process.



Within 30 days from your date of hire:

- Review the Benefits Guidebook & Benefits Website.** Plan and eligibility details, premium information, required notices and disclosures, useful reference material are provided within our Benefits Guide. The benefits website houses in depth plan descriptions/documents, and useful links to carrier resources. It is important that you review all documents related to any plan that you intend to enroll in. Click the link to access the Benefits Website: <https://uplift.benevibe.co/>.
- Evaluate any in-force insurance policies.** If you are currently enrolled in coverage outside of Uplift, it may benefit you to compare your current plan documents to the plan documents for Uplift’s coverage. Our benefit counselors are equipped to help you verify that your benefits package compliments the coverage that your family currently has in place.
- Ask questions.** If you have questions about any of the material that you have reviewed, you may contact the Benefits Service Center at (866) 409-3174.
- Gather dependent and beneficiary information.** You will be required to provide the name, date of birth, SSN, and address for any dependents you enroll in coverage. It is also vital that you provide accurate contact information for your beneficiaries.
- Visit the Benefits Enrollment website or call the Benefits Service Center at (866) 409-3174 for questions to process your enrollment. You have two options for enrollment:**
 - You may enroll online using the <https://transamerica.benselect.com/enroll>. (In addition to enrolling in benefits, you may add/update dependent and beneficiary, access enrollment confirmations, insurance applications and other important plan documents.)
 - You may contact the Benefits Service Center via telephone.

Benefits Service Center
Phone: (866) 409-3174
Hours: M-F 8:00 am - 7:00 pm
- Carefully review your elections in Selerix.** Make any corrections or contact the Benefits Service Center for assistance.
 - Proper address and contact information
 - Appropriate coverage, costs, and effective dates
 - Updated dependent and beneficiary information
- Plan for the financial impact.** Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- Review your paycheck stub(s).** Premiums for the current month are paid on the last day of the month for salaried employees, and on the 15th and the last day of the month for hourly employees. Ensure that any required adjustments to your pay appear as you expected, and immediately notify Talent Management of any discrepancies.
- Watch for/Print new ID cards.** Carrier updates will be processed within 5 business days from the date your enrollment is processed. You may print ID cards online no sooner than 10 business days after completing your enrollment. If you make changes that require new ID cards, the medical provider will issue new medical/Rx cards within 14 business days.

Please do not hesitate to reach out to PEC or your Talent Management department with any questions/concerns. It is our pleasure to assist!

QLE CHECKLIST

A *Qualifying Life Event (QLE)* is a change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a *Special 30-Day Enrollment Period*, allowing you to enroll in or change your health insurance outside the yearly *Open Enrollment Period*.

Qualifying life events include:

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent’s loss of eligibility (attainment of limiting age or change in student status);
- A change in associate’s, spouse’s, or dependents’ work hours;
- A termination or commencement of employment of associate’s spouse or eligible dependent with coverage;
- An entitlement to Medicare or Medicaid;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

The birth of a child is a recognized Qualifying Life Event (QLE). Employees may enroll in coverage, even if they previously declined during open enrollment, and may add the newborn to an existing plan or elect coverage for themselves and eligible dependents.

An employee must ensure the change in coverage is consistent with the status change. For example, if the employee gets married, he/she has 30 calendar days to enroll the new spouse or drop coverage if the employee will be added to the spouse’s plan.

Due to Texas Senate Bill 51 guidelines, medical termination requests may be processed the first of the month following the date in which the Life Event is entered. This may result in a modification to your medical termination and medical effective change dates.

If you have experienced a Qualifying Life Event and wish to update your benefits enrollment, you are required to complete the following task within 30 days:

- To begin your QLE process, please complete an iHelp ticket for QLE changes by emailing people@uplifteducation.org

After your change has been processed:

- Review your confirmation.** Carefully review the changes and immediately advise PEC of any discrepancies.
 - Proper address and contact information
 - Appropriate coverage, costs, and effective dates
 - Updated dependent and beneficiary information
- Plan for the financial impact.** Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- Review your paycheck stub(s).** Premiums for the current month are paid on the last day of the month for salaried employees and on the 15th and the last day of the month for hourly employees. Ensure that any required adjustments to your pay appear as you expected and immediately notify Talent Management discrepancies.
- Watch for/Print new ID cards.** Carrier updates will be processed within 5 business days from the date your enrollment is processed. You may print ID cards online no sooner than 10 business days after completing your enrollment. If you make changes that require new ID cards, the medical provider will issue new medical/Rx cards within 14 business days.

Please do not hesitate to reach out to PEC or your Talent Management department with any questions/concerns. It is our pleasure to assist!

FMLA LEAVE PROCESS

The Family and Medical Leave Act (FMLA) provides eligible employees with job-protected leave for qualifying medical reasons up to 12 weeks (60 days). Leave may be taken on a continuous or intermittent basis.

Eligibility	Qualifying events
Worked for employer at least 12 months	Birth/adoption/bonding of a child
Worked at least 1,250 hours in previous 12 months	Serious health condition
	Caring for an immediate family member
	Military family leave

Leave Workflow Process:

1. Notify your supervisor and People Team of your desire to take a leave of absence, including anticipated dates.
 - o Notice should be:
 - 30 days in advance when foreseeable
 - As soon as practicable for emergencies
2. Employee submits documentation (within 15 calendar days of request)
 - o *Uplift is not responsible for administrative or processing fees*
 - o Completed medical certification
 - o Supporting documents if required
3. Review and designate leave
 - o Review documentation
 - o Approve or deny leave
 - o Provide designation notice
4. Designation includes:
 - o Approved leave dates
 - o Responsibilities of employee while on a leave of absence
 - o Paid leave and Unpaid leave information
 - o Benefits information
5. Return to Work
 - Fitness-for-duty certification is required (Maternity and Personal Health Conditions)
 - MUST be submitted PRIOR to returning to work
 - Leave case closed



Maternity and Parental Leave

FMLA leave for maternity/paternal can be take consecutively or on an intermittent basis. You can review further information on Uplink.

[Leave, Absences, and Accommodations Webpage](#)

Uplift Family Leave (UFL) Paid Leave Benefit

After you exhaust your vacation (if applicable), local, and/or state leave balances while on FMLA leave, the Uplift Family Leave benefit will automatically be applied to approved FML absences of employees who are on leave due to birth or to take care of a family member. UFL benefit will not be applied to the absences of those out on leave for their own serious medical condition or illness.

Uplift Family Leave (UFL) is a paid benefit, not a separate leave designation, that provides up to 30 paid workdays for eligible employees who are on approved FMLA leave and have exhausted all available paid leave balances, including PTO. This benefit allows employees to continue receiving wages while on FMLA leave after their paid leave has been used. Employees must meet the applicable eligibility requirements to qualify for the UFL benefit.

[Uplift Family Leave \(UFL\) FAQs](#)

Benefits - Qualifying Life Event

If you wish to add your newborn to your medical plan, or if you are not enrolled in medical coverage and wish to enroll yourself and your newborn, please email People@UpliftEducation.org and attach your little one’s Verification of Birth document. An iHelp ticket will be created. After we confirm your qualifying life event (QLE) via iHelp, you will need to call the Benefits Call Center at 1-866-409-3174 to finalize and confirm your QLE changes.

You have 30 days from baby’s date of birth to enroll them in medical coverage. Coverage will be effective on the date of birth. Please be sure to review the monthly premium amount for your elected plan.

[Benefits Webpage](#)



MEDICAL

Cigna

The medical program, administered by Cigna, provides the framework for your good health and well-being. In order to better meet the varying needs of our employees, Uplift is offering four medical plans described below.

Highlights	OAP In - High Deductible	OAP HDHP (HSA elig.)		OAP In - Low Deductible	OAP Grandfathered (Closed)	
Network Name	Open Access Plus					
Network Type	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network
Plan Year Deductible						
Individual	\$2,500	\$3,400	\$5,500	\$1,200	\$1,000	\$2,000
Family	\$5,000	\$6,000	\$11,000	\$3,600	\$3,000	\$6,000
Out of Pocket Maximum						
Individual	\$8,150	\$7,050	\$20,250	\$6,900	\$7,900	\$23,700
Family	\$16,300	\$14,100	\$40,500	\$13,800	\$15,800	\$47,400
Coinsurance	70%	70%	50%	80%	80%	60%
Office Visits						
Preventative Services	No charge	No charge		No charge	No charge	
Primary Care	\$30 copay	70% after ded.***	50% after ded.***	\$30 copay	\$30 copay	60% after ded.***
Specialist	\$70 copay	70% after ded.***		\$70 copay	\$70 copay	
Urgent Care	\$50 copay	70% after ded.***		\$50 copay	\$50 copay	
MDLive Copay						
Primary/Urgent Care	\$30 copay	70% after ded.***		\$30 copay	\$30 copay	
Specialty/Behavioral Care	\$70 copay	70% after ded.***		\$70 copay	\$70 copay	
Inpatient	70% after ded.***	70% after ded.***	50% after ded.***	80% after ded.***	\$150 + 80% after ded.***	60% after ded.***
Outpatient	70% after ded.***	70% after ded.***	50% after ded.***	80% after ded.***	\$150 + 80% after ded.***	60% after ded.***
Emergency Room	70% after ded.***	70% after ded.***		80% after ded.***	\$250 copay + 80% after ded.***	
Prescription Copays**	\$100 Brand ded.	Deductible Incl. in Medical		\$150 Brand ded.	\$150 Brand ded.	
<i>Retail (30-day)</i>						
Generic Formulary	\$15 copay*	\$10 copay* after ded.		\$15 copay*	\$20 copay*	
Brand Formulary	\$30 copay	\$30 copay after ded.		\$30 copay	\$40 copay	
Non Preferred Brand	\$60 copay	\$60 copay after ded.		\$60 copay	\$60 copay	
Specialty	\$80 copay	\$80 copay after ded.		\$80 copay	\$80 copay	
<i>Mail (90-day)</i>						
Generic Formulary	\$45 copay	\$30 copay after ded.		\$45 copay	\$60 copay	
Brand Formulary	\$90 copay	\$90 copay after ded.		\$90 copay	\$120 copay	
Non Formulary	\$180 copay	\$180 copay after ded.		\$180 copay	\$180 copay	
Specialty	\$80 copay	\$80 copay after ded.		\$80 copay	\$80 copay	

*\$0 for certain generics ded. = deductible
 ** Prescription Benefits listed are In-Network Benefits. Visit the [Cigna Pharmacy Benefits](#) page for pricing and information. Select Performance 3 Tier from the drop-down menu.
 *** This is the percentage amount covered by Cigna after the deductible has been satisfied.

Medical Deductions	Monthly Premiums			
	OAP In - High Deductible	OAP HDHP (HSA elig.)	OAP In - Low Deductible	OAP Grandfathered (Closed)
Employee	\$78.60	\$38.00	\$155.48	\$628.51
Employee + Spouse	\$823.59	\$770.42	\$846.15	\$1,918.59
Employee + Child(ren)	\$348.96	\$314.92	\$389.33	\$1,022.26
Family	\$1,080.61	\$1,016.19	\$1,185.80	\$2,358.26



Compare plans

Get emergency medical transportation coverage to protect what matters most.

With a MASA plan, you'll have an additional layer of financial protection from the out-of-pocket costs of medical transportation. Explore the options below to compare the benefits offered in each plan.

Gain peace of mind and shield your finances knowing there's a MASA plan best suited for your needs.



	Emergent Plus plan	Emergent Premier plan	Platinum plan
Emergency Ground Ambulance Coverage	● ²	● ²	● ²
Emergency Air Ambulance Coverage	● ²	● ²	● ²
Hospital to Hospital Ambulance Coverage	● ²	● ²	● ²
Repatriation to Hospital Near Home Coverage	● ²	● ³	● ⁴
Post Admission Continued Care Transportation Coverage		● ¹	
Sick While Away From Home Expense Protection		● ⁴	
Minor Return Transportation Coverage		● ³	● ³
Pet Return Transportation Coverage		● ³	● ³
Patient Return Transportation Coverage			● ⁴
Companion Transportation Coverage			● ³
Hospital Visitor Transportation Coverage			● ³
Mortal Remains Transportation Coverage			● ⁴
Vehicle & RV Return Coverage			● ³
Organ Retrieval & Organ Recipient Transportation Coverage			● ¹

Coverage territories

- 1: United States only.
- 2: United States, Canada.
- 3: United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.
- 4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or under certain U.S. travel advisories as long as the member has provided ten (10) day notice.

Benefit descriptions

Emergency Ground Ambulance Coverage

MASA covers out-of-pocket expenses for emergency ground transportation to a medical facility for you or your dependent family member.

For policies that provide an indemnity benefit, MASA pays you an indemnity amount for your or your dependent family member's emergency ground transportation to a medical facility.

Emergency Air Ambulance Coverage

MASA covers out-of-pocket expenses for emergency air transportation to a medical facility for you or your dependent family member.

For policies that provide an indemnity benefit, MASA pays you an indemnity amount for your or your dependent family member's emergency air transportation to a medical facility.

Repatriation to Hospital Near Home Coverage

Should you need continued care, and your care provider has approved moving you to a hospital nearer to your home, MASA coordinates and covers expenses for ambulance transportation to the approved medical facility.

Hospital to Hospital Ambulance Coverage

When specialized care is required but not available at the initial emergency facility, MASA provides coverage for transferring you to the nearest appropriate medical facility.

Post Admission Continued Care Transportation Coverage

Should you need care in a rehabilitation facility, skilled nursing facility, long-term care facility, hospice, or at home after an emergency, your out-of-pocket expenses for transport are eased with MASA.

Sick While Away From Home Expense Protection

Should you be required to quarantine while traveling, MASA will cover some of your extended hotel expenses.

Minor Return Transportation Coverage

In the event your minor child traveling with you is left unattended due to your emergency transport, MASA coordinates services and covers expenses to return your child safely home.

Hospital Visitor Transportation Coverage

Should you be hospitalized more than 100 miles from home, MASA coordinates and covers the cost of round-trip air transportation for a companion to join you.

Patient Return Transportation Coverage

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers costs associated with your commercial airline transport home.

Companion Transportation Coverage

MASA coordinates services and covers costs for a companion to accompany you during your emergency air ambulance transport.

Companion Return Transportation Coverage

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers the costs associated with your companion accompanying you on commercial airline transport home.

Pet Return Transportation Coverage

If you are traveling with your pets and an emergency occurs requiring your medical transport, MASA coordinates services and covers expenses for returning up to two pets to your home.

Mortal Remains Transportation Coverage

In the event that you pass away more than 100 miles from home, MASA coordinates services and provides coverage for air transport for your remains to be returned home.

Vehicle & RV Return Coverage

Should a travel emergency occur requiring you to leave your vehicle or RV by ambulance, MASA provides services and covers expenses associated with returning your vehicle or RV to your home.

Organ Retrieval Transportation Coverage

Should you need an organ transplant, MASA coordinates and provides coverage for getting you or the organ to the transplant location.

About MASA

In 1974 MASA pioneered the first prepaid plan program providing coverage for medical emergency air and ground transportation costs.

Now with over 400 team members, MASA is offered throughout the U.S. — and provides complete nationwide coverage for emergency transportation.

Protect your employees, their families, and their financial future with MASA.

MASA Deductions	Monthly Premiums
Emergent Plus Plan	\$13.00
Emergent Premier Plan	\$17.50
Platinum Plan	\$37.00



HEALTH SAVINGS ACCOUNT

Consolidated Admin Services (CAS)

A Health Savings Account (HSA) works with a High Deductible Health Plan (HDHP), and lets you set aside a portion of your paycheck, before taxes, into an account to help you pay for qualified medical expenses that aren't covered by your plan. It can also help you plan for future medical expenses.

Note: HSA funds can roll over from year to year!

How does an HSA work?

In 2026, the IRS increased the HSA maximums. You can deposit up to \$4,400 for yourself or up to \$8,750 for your family, into your HSA. For those 55 and older, \$1,000 catch-up (additional) contributions can be made to their HSA. This limit is set by the IRS. You can use money in your HSA to pay for insurance deductibles and medical care/supplies like dentistry, ophthalmology, and prescription drugs. When you enroll, an account will be created for you. There is a \$2.50 administrative maintenance fee deducted each month from your paycheck. You'll be given access to a secure, easy-to-use web portal where you can track your account balance and submit requests for reimbursements.

In addition, you'll be issued an HSA Benefits Card you can use at point-of-sale to pay for qualified medical expenses. You can request reimbursement distributions online at www.consolidatedadmin.com or call **(877) 941-5956**. Payment will be made based on your available funds. Distributions can be made payable to you or a provider. Contributions above the yearly limit are called excess contributions and could be subject to a six percent excise tax.

Visit www.hsastore.com to buy HSA eligible products, search for services and learn about your HSA.

IRS HSA Contribution Limits	2026
Individual	\$4,400
Individual (age 55+)	\$5,400
Family	\$8,750
Family (age 55+)	\$9,750

HSA Eligibility

You are eligible to open and contribute to an HSA if:

- You are enrolled in a High Deductible Health Plan (HDHP);
- You are not covered by your spouse or domestic partner's non-HDHP health plan;
- You are not eligible to be claimed as a dependent on someone else's tax return;
- You are not enrolled in Medicare or TRICARE; and
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care (service-related care will not be taken into consideration).

Triple Tax Savings!

You can take advantage of 'triple tax savings' when you open an HSA with Consolidated Admin Services (CAS). That's because...

- Your contributions are pre-tax (or tax deductible);
- Your account balance grows tax-free; and
- Withdrawals for qualified medical expenses are also tax-free.





FLEXIBLE SPENDING ACCOUNT

CAS

The Flexible Spending Accounts (FSA) administered by Consolidated Admin Services (CAS) allow you to set aside pre-tax dollars from your paycheck to pay for many health care and dependent care expenses. By paying for these expenses with pre-tax dollars, you reduce the amount of your taxable income and increase your take-home pay. You may choose to participate in one or both FSAs - whether you elect any other benefits.

How much can I contribute?

To participate, decide how much you would like to contribute to one or both accounts for the year. *The money you allocate to each account is automatically deducted from your paycheck each pay period before taxes are calculated.*

- Health Care Flexible Spending Account you could contribute up to the maximum of \$3,400 for the 2026 year.
- Dependent Care Flexible Spending Account you could contribute up to the maximum of \$7,500 for the 2026 year.

The exceptions are:

- If you and your spouse file separate tax returns, you may contribute \$3,750 per year.
- If your spouse is employed, your maximum contribution is the lesser of your spouse’s taxable income (but no more than \$7,500)
- If your spouse is a full-time student or they are physically or mentally disabled, your maximum contribution is \$3,750 a year if you claim expenses for one dependent and \$7,500 a year if you claim expenses for two or more dependents.

IRS FSA Contribution Limits	2026
Health Care Flexible Spending Account (Individual)	\$3,400
Dependent Care Flexible Spending Account	\$7,500

Note: Health Care FSA funds can carryover a maximum of \$680 for the year of 2026. There is a \$3.50 administrative maintenance fee per account deducted each month from your paycheck.

General Rules and Restrictions

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care FSA and Dependent Care FSA:

- You may only use the money in your FSAs to reimburse expenses that you have incurred during the plan year for which the FSA was established.
- IRS requires you to use all of 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.
- You cannot transfer monies between Health Care and Dependent Care FSAs.
- You cannot begin, stop, or change the amount of your FSA contributions during the calendar year unless you experience a Qualifying Life Event (such as: marriage, divorce or the birth/adoption of a child). Create an iHelp ticket to make changes to your benefits due to a qualifying life event.
- You cannot claim expenses that are reimbursed through your FSA as a deduction on your income tax return.
- Reimbursement for Dependent Care FSA claims is only up to the total amount that is in your account at that time.
- The dependent care provider cannot be anyone considered your dependent for income tax purposes (such as one of your older children). In order to be reimbursed, you are required to provide the tax identification number or Social Security number of the party providing care.
- Your Medical FSA will end on the date your employment terminates. Medical services received before your termination date will still be eligible for reimbursement. You have 90 days from your termination date to submit claims to CAS for reimbursement.

Visit www.fsastore.com to buy FSA eligible products, search for services and learn about your FSA.



DENTAL

Cigna

Cigna gives you the freedom to choose whether you would like to visit an in-network or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Network: Cigna Dental

See www.cigna.com or call **(800) 997-1654** for a list of network providers.

Highlights	Low Plan		High Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible Individual Family Waived for Preventive	\$50 \$150 Preventive		\$50 \$150 Preventive	
Annual Maximum Benefit	\$1,250		\$1,500	
Orthodontia Lifetime Maximum	None		\$1,000	
Diagnostic & Preventive	100%	100%	100%	100%
Basic	80%	80%	80%	80%
Major	Not covered	Not covered	50%	50%
Orthodontia	Not covered	Not covered	50%	50%
Diagnostic & Preventive	<ul style="list-style-type: none"> Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays 		<ul style="list-style-type: none"> Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays 	
Basic	<ul style="list-style-type: none"> Emergency Care to relieve pain (administered at In-Network coinsurance) Fillings Oral Surgery - Simple Extractions Anesthetics Brush Biopsy 		<ul style="list-style-type: none"> Emergency Care to relieve pain (administered at In-Network coinsurance) Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Brush Biopsy 	
Major	Not covered		<ul style="list-style-type: none"> Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, Inlays, and Dentures Crowns / Inlays / Onlays Stainless Steel / Resin Crowns Dentures Bridges 	
Orthodontia <i>(dependent child to age 19 only)</i>	Not covered		Diagnostics and Treatment	

Dental Deductions	Monthly Premiums	
	Low Plan	High Plan
Employee	\$25.04	\$44.53
Employee + Spouse	\$49.11	\$89.34
Employee + Child(ren)	\$66.71	\$78.43
Family	\$98.50	\$126.55



VISION

Cigna / EyeMed

Cigna / EyeMed is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Network: Insight

See member.eyemedvisioncare.com/cigna/en or call **(800) 997-1654** for a list of network providers.

Highlights	Plan	
	In-Network	Out-of-Network (Reimbursement)
Exam with dilation as necessary	\$10 copay	Up to \$45
Retinal Imaging	Up to \$39	Not covered
Lenses		
Single		Up to \$32
Bifocal	\$10 copay	Up to \$55
Trifocal		Up to \$65
Lenticular		Up to \$80
Contact Lenses*		
Contact Lens Fit and Follow Up	Standard: Up to \$40; Premium: 10% off retail price	Not covered
Medically Necessary	\$0 copay, Paid in full	Up to \$210
Conventional	\$0 copay/\$130 Allowance/15% off balance	Up to \$105
Disposable	\$0 copay/\$130 Allowance/Plus balance over \$130	Up to \$105
Frames	\$0 Copay/\$130 Allowance/20% off balance over \$130	Up to \$78
Service Frequencies		
Exams	Every 12 months	
Lenses or Contact Lenses	Every 12 months	
Frames	Every 12 months	
Additional Coverages	Interested in Laser Vision Correction service such as LASIK? Visit MyCigna.com and search for Healthy Rewards® for details.	Not covered
	One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.	Not covered

*Contact lenses are in lieu of eyeglasses and frames.

Vision Deductions	Monthly Premiums
Employee	\$6.19
Employee + Spouse	\$12.36
Employee + Child(ren)	\$13.05
Family	\$20.48

Additional EAP Services for those enrolled in Cigna Medical Coverage

Emotional health matters

We're here to help you take care of it.



Life is full of ups and downs. But if feelings of sadness, worry or anxiety are becoming more frequent and making daily life hard, it might be time to get extra help. Your plan offers support for whatever challenge you're facing — 24/7/365.

Where to get help



24/7 unlimited immediate clinical consultations, for any need big or small, lasting up to 30 minutes. Just call the number on the back of your ID card.



100% follow up to make sure your needs are met. After you've engaged with our team, we'll check in with you digitally to see if you need additional support.



Live chat on myCigna.com



Clinical support services provide dedicated assistance for a broad range of conditions, including autism, eating disorders, intensive behavioral case management, substance use, and opioid and pain management.

Programs that provide support

- Three face-to-face visits with a licensed behavioral health provider in our employee assistance program (EAP) network¹ at no additional cost. To get an EAP code, visit **myCigna.com** and chat with us online or select the link that displays with your online provider search.
- Unlimited telephone support and access to work-life resources.
- Access to legal services, including a 30-minute consultation with a program attorney for legal issues, with 25% off select fees if the program attorney is retained.²
- Access to financial services, such as 25% off tax preparation and a 30-minute complimentary phone consultation with a financial specialist.¹
- Access to IdentityForce, a comprehensive identity theft protection program at no additional cost.³

All disclosures appear at the end of this document.

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Our network makes it easy to find the care you need

- Access Cigna Healthcare's large national network of clinicians, counselors, psychologists and psychiatrists, including virtual providers
- Appointment availability in as little as two days⁴
- Online therapy with a licensed therapist through Talkspace⁵
- Behavioral health coaching through Headspace Care via text-based chat⁵
- Centers of Excellence for Adult Mental Health, Child & Adolescent Mental Health, Eating Disorders and Substance Use⁶

Resources ready whenever you are

- **Headspace for Cigna Healthcare**⁵ has exclusive content for Cigna Healthcare members available at no additional cost.
- This guided self-care app for everyday mental health support is proven to reduce stress, improve sleep and overcome burnout. Get access to science-backed guided programs and collections for burnout, sleep, focus, meditations and more. The app is integrated into the myCigna ecosystem so if your symptoms become more serious, we'll quickly and easily steer you to care.

 **Get started or register at myCigna.com today.**

Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.



1. Employee assistance program services are in addition to, not instead of, your health plan benefits. These services are separate from your health plan benefits and do not provide reimbursement for financial losses. Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply. Program availability may vary by plan type and location, and programs are not available where prohibited by law.
2. Our legal services provide access to a nationwide network of participating law firms and attorneys, all in good standing with their local bar associations. Get an initial, no-cost consultation and a discount on legal fees for help with family law, real estate concerns, estate planning and more. Identity theft consultation services are also available. Legal consultations related to employment-related matters are not available under this program.
3. Identity Force program and services are provided by independent companies/entities and not by The Cigna Group or its operating subsidiaries. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change. References to third-party organizations or companies, and/or their products, processes or services, does not constitute an endorsement or warranty thereof. Your use of such products, processes or services are at your sole risk. Product may be updated or modified prior to availability. Product availability may vary by location and plan type and is subject to change.
4. Two-day appointments available through provider partners: Alma, Bicycle Health, Brightside, Headway, Meru Health, and Path.
5. Program services are provided by independent companies/entities and not by Cigna Healthcare. Programs and services are subject to all applicable program terms and conditions. Program availability is subject to change.
6. The Cigna Healthcare Center of Excellence designation is a partial assessment of quality and cost-efficiency and should not be the only basis for decision-making (as such measures have a risk of error). Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Quality designations and ratings found in Cigna Healthcare online provider directories are not a guarantee of the quality of care that will be provided to individual patients.

All health care providers and service providers are solely responsible for their care and/or services.

Providers are not agents of Cigna Healthcare. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group.

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TELUS Health Employee Assistance Program (EAP)

Uplift Education
Group Number: 755541



Who is TELUS Health?

TELUS Health is a global leader in integrated health and wellness solutions. Through Voya Employee Benefits, TELUS Health offers you and your loved ones confidential, comprehensive support for mental, emotional, financial, and physical wellbeing. TELUS Health licensed clinicians and care managers help you navigate life's challenges, providing personalized solutions and connecting you to optimal resources anytime, anywhere.



Who is eligible for TELUS Health EAP?

EAP services are available to you and your household dependents, including spouses, domestic partners, and immediate family members. Eligibility begins immediately upon hire, with no enrollment required.



What type of support will you receive?

You will receive professional, live support for a wide range of personal and work-related challenges. All clinicians are licensed professionals, including counselors, social workers, and care managers, supported by a multi-disciplinary team. TELUS Health provides:

- 24/7 access via phone, web, and mobile app,
- 24/7 live chat support through the mobile app
- Access to licensed clinicians for 1:1 support
- Personalized care plans tailored to your unique needs
- Digital wellbeing tools, including self-guided programs and virtual peer groups
- Legal, financial, and identity theft support
- Work-life services: childcare, elder care, education, adoption and more
- Manager consultations and workplace support
- Wellbeing and life coaching for personal and professional growth
- Clinically appropriate, solution-focused counseling per issue, per year

ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies

How to get started

- Online: one.telushealth.com
- Call: **1-833-303-3750** or **1-919-341-7440**

User name: Voya

Password: eap

Based on your situation, you'll be paired with a designated clinician who will serve as a primary point of contact for you.

Download the TELUS Health One app today

Digital access & App features

TELUS Health's digital platform is designed for easy, secure access to care. The mobile and web app includes:

- Direct access to your care team, care plans and self-guided digital wellbeing programs with interactive content
- 24/7 access to live chat support
- Resource library with educational videos and articles
- Dynamic wellbeing assessments with personalized recommendations

App Store is a service mark of Apple Inc. Google Play is a service provided by Google LLC.



Scan here for the App Store



Scan here for Google Play

ReliaStar Life Insurance Company (Minneapolis, MN) and ReliaStar Life Insurance Company of New York (New York, NY), both Voya Financial® businesses, work with TELUS Health (US) Ltd., a Delaware corporation, to offer Employee Assistance Program ("EAP") and Total Mental Health Services as requested by ReliaStar customers. EAP Services are provided by TELUS Health and its affiliates. TELUS Health is not affiliated with the Voya® family of companies. EAP Services provided are the sole responsibility of TELUS Health. Product availability and provisions may vary by state. Please access and read TELUS Health's User Terms which is available at this link: one.telushealth.com.

The information provided does not, and is not intended to, constitute legal or medical advice; instead, all information and content herein is provided for general informational purposes only. As a requirement in making such EAP services available to its employees, ReliaStar customers shall not mandate that their employees use TELUS Health services. The decision to use an EAP Service provider is complex and nothing contained within this material is intended to replace medical advice from a properly licensed healthcare provider.

Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Voya Employee Benefits is a division of ReliaStar Life Insurance Company. Product availability and specific provisions may vary by state.

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DISABILITY

Voya - New Carrier!

SHORT-TERM DISABILITY (STD) - Employee Paid

Voya’s Short-Term Disability insurance can replace a portion of your weekly income if you have a covered disability that keeps you from working. As long as you remain disabled, you can receive payments for up to **25 weeks**. You’re generally considered disabled if you’re unable to do important parts of your job and your income suffers as a result. This plan covers off-the-job injuries and illnesses only. Employees are required to use PTO days prior to filing a claim.

Maternity leave and Short-Term Disability (STD) benefits are applicable only during the period in which the employee is medically unable to work due to pregnancy and childbirth. Leave taken for bonding purposes is not covered under STD benefits.

Highlights	Short-Term Disability
Weekly Benefit	Up to 60% of weekly salary in \$50 increments (up to \$1,000 per week)
Elimination Period	7 days following injury or illness
Benefit Duration	25 weeks
Pre-Existing Limitations	3 month look back / 12 month waiting period

Please speak to a licensed Benefit Counselor for personalized rates.

LONG-TERM DISABILITY (LTD) - Employer Paid

Voya’s Long-Term Disability Insurance provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness at **no cost to you during your employment**. This plan covers both on- or off-the-job injuries and illnesses.

Highlights	Long-Term Disability
Monthly Benefit	50% of monthly salary (not to exceed \$7,500)
Elimination Period	180 days following injury or illness
Benefit Duration	To Social Security Normal Retirement Age (SSNRA)
Pre-Existing Limitations	3 month look back / 12 month waiting period

Why is STD and LTD coverage so valuable?

- **It’s flexible.** You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
- **It’s affordable.** Your cost is based on your age when you buy the insurance and will not increase when you move into the next age band.
- **It’s convenient.** Your premiums are automatically deducted from your paycheck.



LIFE AND AD&D

Voya - New Carrier!

GROUP BASIC LIFE INSURANCE & AD&D - Employer Paid

Uplift Education provides Basic Life insurance and Accidental Death and Dismemberment (AD&D) insurance through Voya. Uplift Education provides Basic Life insurance **equal to the employee’s salary (rounded to the next-highest \$1,000) up to a maximum of \$100,000 at no cost to you during your employment.** Please **call** the Benefits Service Center **to designate or update beneficiary information.**

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. The company provides a guaranteed issue amount equal to the basic life insurance amount.

Note: Life and AD&D benefit reduces to 65% at age 65 and to 50% at age 70.

VOLUNTARY LIFE INSURANCE - Employee Paid

In addition to the company paid life insurance, you have the opportunity to elect additional life insurance through Voya. AD&D amount will reflect the Voluntary Life insurance amount.

Highlights	Voluntary Life and AD&D
Employee Benefit	
Benefit Amount	Increments of \$10,000 up to the lesser of 5 times annual salary or \$500,000
Maximum Benefit	\$500,000
Guarantee Issue	\$300,000
Spouse Benefit	
Benefit Amount	Increments of \$5,000 to a max of \$100,000 not to exceed 50% of employee benefit
Maximum Benefit	\$100,000
Guarantee Issue	\$30,000
Child Benefit	
Benefit Amount	\$10,000
Maximum Benefit	\$10,000
Guarantee Issue	\$10,000

Note: Voluntary Life and AD&D benefit reduces to 65% at age 65 and to 50% at age 70. Employees may elect additional coverage with the submission and approval of an Evidence of Insurability form.

Please speak to a licensed Benefit Counselor for personalized rates.



ACCIDENT

Voya - New Carrier!

You do everything you can to keep your family safe, but accidents do happen. It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Voya's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries. The Accident policy will pay a **\$50 wellness benefit** once per calendar year, per person.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like copays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You may keep your coverage if you change jobs or retire. You'll be billed directly.

Highlights	Plan
Wellness Benefits (per calendar year)	\$50
Common Carrier Accidental Death	Employee: \$100,000 Spouse: \$50,000 Child: \$25,000
Dismemberment	Up to \$28,000
Urgent Care (per visit)	\$300
Follow-up Visits (up to 6 visits)	\$150
Major Diagnostic Exams (per service)	\$500
Ambulance - Ground/Air (per service)	\$600/\$2,500
Surgery	Up to \$2,500
Fractures	Up to \$10,000
Dislocations	Up to \$8,000
Concussion (per concussion)	\$450
Coma (per coma)	\$250
Lacerations	Up to \$960
Eye Injury (per injury)	Up to \$420
Hospital Admission (per admission)	\$2,000
Critical Care Unit Admission (per admission)	\$4,000
Hospital Confinement (per day, up to 1 year)	\$400
Critical Care Unit Confinement (per day, up to 30 days)	\$800
Physical Therapy (up to 10 per accident)	\$75
Emergency Room Treatment (per visit)	\$350
Transportation (3 times per accident)	\$850
Lodging (per day, up to 30 days)	\$225

Accident Deductions	Monthly Premiums
Employee	\$11.22
Employee + Spouse	\$16.54
Employee + Child(ren)	\$21.32
Family	\$26.64



CRITICAL ILLNESS

Voya - New Carrier!

Voya’s Critical Illness insurance pays a lump-sum cash benefit upon diagnosis of a covered Critical Illness, to help ease your financial and emotional worries. You can use the benefit any way you wish, such as treatment, bill, or child care. The Critical Illness policy will pay a **\$50 wellness benefit** once per calendar year, per person.

Why should I buy coverage now?

- It’s more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You may keep your coverage if you change jobs or retire. You’ll be billed directly.

Highlights	Plan
Benefit Amount	
Employee	\$10,000 to \$50,000 in increments of \$5,000
Spouse	\$5,000 to \$25,000 in increments of \$2,500 up to 50% of the employee benefit
Child	50% of employee benefit
Guaranteed Issue	
Employee	\$50,000
Spouse	\$25,000
Child	All child amounts are guaranteed
Cancer	
Heart Attack	
Major Organ Transplant	
Kidney Failure	
Stroke	
Loss of Hearing, Sight or Speech	100%
Coma	
Permanent Paralysis	
Benign Brain Tumor	
Alzheimer's Disease	
Carcinoma in Situ	50%
Infectious Contagious Disease	
Coronary Arteriosclerosis	
Skin Cancer	10%

Please speak to a licensed Benefit Counselor for personalized rates.

HOSPITAL INDEMNITY

IMPORTANT: 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.
- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.

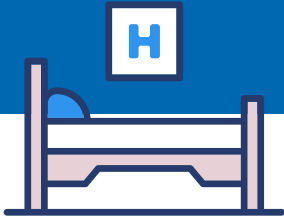
Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



HOSPITAL INDEMNITY

Voya - New Carrier!

Voya’s Hospital Indemnity plan can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds that can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles.

This plan also allows you to continue coverage in the event that your employment ends or when the policy is terminated and not being replaced.

Note: The benefits in this plan are compatible with a Health Savings Account (HSA).

Highlights	Plan
Hospital Admission	\$1,000
Critical Care Unit Admission	\$2,000
Rehabilitation Facility admission	\$1,000
Hospital Confinement <i>(per day, up to 15 days)</i>	\$200 daily
Critical Care Unit Confinement <i>(per day, up to 15 days)</i>	\$200 daily
Rehabilitation Facility Confinement <i>(per day, up to 15 days)</i>	\$200 daily
Health Screening Benefit <i>(once per year)</i>	\$50

Hospital Indemnity Deductions	Monthly Premiums
Employee	\$17.55
Employee + Spouse	\$31.49
Employee + Child(ren)	\$27.89
Family	\$41.83



CANCER

Guardian

While most people can appreciate the importance of having health and disability insurance, the costs of cancer can go well beyond what those cover. Cancer Insurance is an affordable way to provide additional funds to help cover out-of-pocket expenses.

The average out-of-pocket cost for patients with cancer is estimated to be \$8,436 a year, including copays, deductibles, treatments, home healthcare, and more. That’s on top of everyday bills like groceries, utilities, and car payments. Cancer Insurance is an affordable way for you to address a barrage of costs while strengthening your employee benefit package.

Highlights	Low Plan	Medium Plan	High Plan
Hospital and Related Benefits (daily)			
Continuous Hospital Confinement (<i>first 31 days</i>)	\$300	\$300	\$400
Government or Charity Hospital	N/A	\$300	\$400
Extended Care Facility (<i>up to 90 days per year</i>)	\$100	\$100	\$150
At-Home Health Care (<i>up to 30 visits per year</i>)	N/A	\$50 / visit	\$100 / visit
Hospice Care Center (<i>up to 100 days per lifetime</i>)	\$50	\$50	\$100
Cancer Initial Diagnosis	\$5,000	\$5,000	\$5,000
Radiation, Chemotherapy, and Healing			
Radiation / Chemotherapy for Cancer (<i>every 12 months</i>)	Up to \$10,000	Up to \$10,000	Up to \$15,000
Blood, Plasma, and Platelets (<i>every 12 months</i>)	Up to \$5,000 per year	Up to \$5,000 per year	Up to \$10,000 per year
Medical Imaging (<i>yearly</i>)	N/A	\$100 (2 / year)	\$200 (2 / year)
Immunotherapy (<i>per month</i>)	\$500 (\$2,500 max)	\$500 (\$2,500 max)	\$500 (\$2,500 max)
Surgery and Related Benefits			
Surgery	Up to \$2,750	Up to \$4,125	Up to \$5,500
Anesthesia (<i>% of surgery</i>)	25%	25%	25%
Second Opinion (<i>per procedure</i>)	\$200	\$200	\$300
RBone Marrow or Stem Cell Transplant			
Bone Marrow	N/A	\$7,500	\$10,000
Stem Cell (<i>50% for 2nd transplant</i>)	N/A	\$1,500	\$2,500
Miscellaneous Benefits			
New or Experimental Treatment (<i>every 12 months</i>)	N/A	Up to \$1,000 / month	Up to \$2,400 / month
Prosthesis (<i>Non-Surgically-Implanted</i>)	\$200 / device	\$200 / device	\$300 / device
Prosthesis (<i>Surgically-Implanted</i>)	\$2,000 / device	\$2,000 / device	\$3,000 / device
Anti-Nausea Benefit (<i>monthly</i>)	N/A	\$150	\$250
Waiver of Premium (<i>for primary insured only</i>)	Yes	Yes	Yes

Cancer Deductions	Monthly Premiums		
	Low Plan	Medium Plan	High Plan
Employee	\$10.88	\$21.70	\$28.08
Employee + Spouse	\$19.98	\$40.62	\$52.04
Employee + Child(ren)	\$12.72	\$27.84	\$35.14
Family	\$21.82	\$46.76	\$59.10



UNIVERSAL LIFE

Transamerica

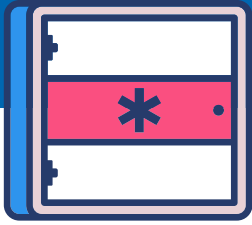
There is no way to know what will happen tomorrow. But there is a way to help ensure you are protected against the unexpected. Transamerica Life Insurance Company's Universal Life insurance can help meet your family's future financial needs in the event of your premature passing. Prudent financial planning can help protect your family's future, offering them greater peace of mind.

Highlights	Plan
Employee Benefit Amount Guarantee Issue	Up to 5x your annual salary, not to exceed \$500,000 Up to \$100,000 (\$10,000 increments)
Spouse Benefit Amount Guarantee Issue	Up to \$100,000 \$25,000
Child Term Rider Benefit Amount Guarantee Issue	Choose from \$10,000 or \$20,000 \$20,000
Additional Benefit Riders	<ul style="list-style-type: none"> Accelerated Death Benefit for Qualified Terminal Condition Accelerated Death Benefit for Living Benefit Benefits Restoration
Additional Advantages	<ul style="list-style-type: none"> Keep your coverage at the same price and benefits if you change jobs or retire. Apply for coverage for family members: spouse, children and grandchildren. Convenient payroll deduction; pay via direct bill, bank draft or credit card if you leave your employer.

Please speak to a licensed Benefit Counselor for personalized rates.

Note: For the **2026-2027 Plan Year**, TransAmerica has approved a *special enrollment window from July 14 to July 30*. During this period, returning employees who had previously waived coverage can now apply for insurance for themselves and their spouses, up to the Guarantee Issue limits specified above, without being required to answer health-related questions.

This is a brief summary of TransElite® Universal Life Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series CPGUL300 and CCGUL300. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.



403(B) RETIREMENT

TCG Group Holdings

A 403(b) plan allows an employee to defer money into a retirement account on a pre-tax or ROTH basis. The earnings in your retirement savings plan may be tax-deferred or tax-free depending on your

contribution type. Eligible employees can enroll in a 403(b) retirement plan immediately upon hire and may change their deferral amount at any time.

For 2026, the maximum employee deferral to a 403(b) account is **\$24,500 per calendar year**. Additionally, participants age 50 and older are permitted to contribute up to an additional **\$10,000 in “catch-up”** contributions per calendar year. Uplift Education neither contributes to nor matches contributions for 403(b). A monthly administrative maintenance fee of **\$1.50** will be deducted in addition to your deferral election.

Interested in getting started? A list of Authorized Investment Providers with phone and website information is available on TCG Group Holdings’ website. Detailed online enrollment instructions can be found at: <http://uplifteducationbenefits.org/403b/enrollment-instructions>

Plan Features

- Employees have a variety of investment options though TCG.
- You may stop or change your contribution at any time by logging into your online account at www.region10rams.org or by calling TCG at **(800) 943-9179**.

TCG Group Holdings

- **Customer Service:** (800) 943-9179
- **Fax:** (888) 989-9247
- www.region10rams.org
- **Email:** 403b@tcgservices.com

Retirement Planning for Educators

Click link to view video: player.vimeo.com/video/766265550





Take Charge Towards a Secure Retirement

Personalized Guidance for District Staff Through TeleWealth™ Virtual Meetings

Whether retirement is near or far, planning for your financial future is essential. As a school district employee, you work tirelessly to support all students and the community. But now it's time to **prioritize your own financial wellbeing** and take control of your financial future.

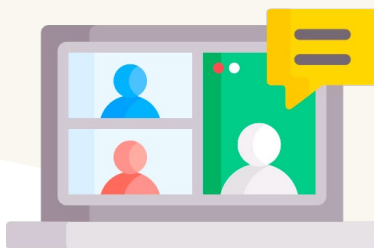
TeleWealth™ Virtual Meetings Convenient, Confidential, Free

Our team is here to help you evaluate your current situation, explore your plan options, and guide you towards your retirement dreams.

Join your meeting with ease from home or school via phone or computer. Meetings are 100% confidential and **free of charge for you and your spouse.**

Get answers to questions like:

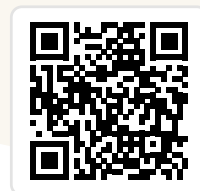
- How does my pension work?
- How much will I need at retirement?
- Does Social Security impact the pension I'm supposed to receive?
- What are 457(b) and 403(b) plans?
- How do I consolidate plans from previous employers?
- How do I choose what to invest in?



Schedule a TeleWealth™ Meeting at www.tcgservices.com/telewealth

For extended hours or weekends, please email hello@tcgservices.com

Scan code for quick meeting booking access



Advisory services and TeleWealth virtual meetings offered through TCG Advisors LLC, a HUB International company, an SEC Registered Investment Advisor. Insurance offered through HUB International. TCG.59.2023



Teacher Retirement System of Texas

1-800-223-8778

Monday-Friday 7:00am - 6:00pm

Main website: <https://trs.texas.gov/>

MyTRS portal: <https://mytrs.texas.gov/>



TRRS administers a retirement plan (pension trust fund) that has been serving the needs of Texas public education employees since 1937. The TRS retirement plan is administered as a qualified governmental retirement plan under the provisions of Section 401(a) of the U.S. Internal Revenue Code of 1986.

TRRS provides service and disability retirement benefits in addition to death benefits.

What is a pension trust fund?

A pension trust fund is a special account where money is set aside and invested to pay retirement benefits to employees in the future. Once the minimum service credit and necessary age requirements are met, you can apply for service retirement and receive a lifetime monthly benefit!

Membership

Your membership begins on your first day of eligible employment with a TRS-covered employer. You must work 20 hours or more each week for a public, state-supported educational institution in Texas to be eligible for TRS membership and retirement plan participation. If you qualify for TRS membership, **participation in the retirement plan cannot be waived.**

Member Contributions

As a TRS member, you're required by State Law to contribute a percentage of your eligible compensation as your share of the funding for your benefits. Your employer is required to deduct the contributions from your salary on a pre-tax basis and forward them directly to TRS each month of eligible employment.

Contributions earn 2% interest which TRS will credit on Aug. 31 of each year.

To view your balance or merge an existing TRS account, visit [MyTRS](#) member account.

Contribution Rates for FY 2026-27

The TRS retirement plan is a defined benefit plan. This means retirement benefits are determined using a formula established by Texas law.

TRRS Retirement Plan	Required Contributions
Employee Retirement Plan Contribution	8.25%
Uplift Retirement Plan Contribution	2.00%
State of Texas Retirement Plan Contribution	8.25%
TRRS-Care* Retiree Health Insurance Plan	Required Contributions
Employee TRS-Care Contribution	0.65%
Uplift TRS-Care Contribution:	0.75%
State of Texas TRS-Care Contribution:	1.25%

Additional Retirement Options

While your TRS pension benefit will provide a valuable source of ongoing retirement income, your pension probably won't provide enough income to ensure a financially secure retirement. For this reason, it is recommended that members enroll in the 403(b) retirement plan administered by TCG Group Holdings. View TRS's [Understanding 403\(b\) Retirement Plans](#) for additional information on the benefit of these plans.

Additionally, view the 403(b) retirement section of this guide for more information on the Uplift voluntary 403(b) retirement plan or view TCG Group Holdings' [Retirement Planning for Educators video](#).

Vesting

If you earn at least five years of membership service credit, you are considered a "vested" TRS member.

Retirement

Your retirement benefits become taxable income in the years in which they are paid to you. If you are preparing for retirement, review the [TRRS Benefits Handbook](#) for more information.

*Upon retirement, you are eligible for medical and prescription drug coverage under the [TRRS-Care program](#).



Fetch the best health coverage for your pet through your voluntary benefits package. With two budget-friendly plans, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

Nationwide offers two plans for you to choose from: My Pet Protection® and My Pet Protection® with Wellness500.¹ Both plans are guaranteed issuance,² have a \$250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.³

	My Pet Protection®	My Pet Protection® with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spay or neuter		✓
And more	✓	✓



Did you know? Nationwide is the industry-first provider of coverage for birds and exotic pets.

How to use your pet insurance plan

- 1 Visit any vet, anywhere.
- 2 Submit claim.
- 3 Get reimbursed for eligible expenses.

<https://partnersolutions.nationwide.com/pet/uplifteducation> | 877-738-7874

[1] Existing members can enroll in My Pet Protection® with Wellness500 during their respective renewal period only. Products and discounts not available to all persons in all states. [2] Guaranteed issuance means any new pets enrolling into a My Pet Protection Plan are eligible for enrollment regardless of health status. Guaranteed issuance does not mean guaranteed coverage since certain exclusions could apply. [3] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions and annual limits. Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Subject to underwriting guidelines, review and approval. Products and discounts not available to all persons in all states. Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Nationwide, the Nationwide N and Eagle, Nationwide is on your side, VetHelpline® and Nationwide PetRxExpress™ are service marks of Nationwide Mutual Insurance Company. Third party marks are the property of their respective owners. ©2024 Nationwide. 23GRP9695A





UPLIFT EDUCATION EMPLOYEE GIVING

As a valued member of our team, you live out our mission every day – showing that community matters and that education makes the difference. Now, you can take that commitment even further by becoming a monthly donor. Even a small monthly gift helps build a stronger future for the students and families we serve. Your support –no matter the amount– demonstrates your belief in the power of education to transform lives and your dedication to being part of something bigger than yourself.

Enroll in monthly donations today!

www.uplifteducation.org/employee-giving

Thank you for being part of the Uplift community.

HEALTH INSURANCE TERMS

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

- **Benefits** - The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim** - A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance** - The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment** - An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible** - A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations** - Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Savings Account (HSA)** - An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **Flexible Spending Account (FSA)** - An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP)** - A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network** - Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary** - A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network** - Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum** - The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition** - Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO)** - A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received within the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP)** - A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges** - The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)** - A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.



FREQUENTLY ASKED Q&A

GENERAL

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

Yes. It is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, must I still complete the Open enrollment process?

Yes. It is important that your employer has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?

Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?

A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for ABC Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?

If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 30 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

MEDICAL

Should I notify my pharmacy and physician of my benefits plan with Cigna?

Yes. On your next visit to the pharmacy or doctor, simply present your Cigna ID card. This will allow the provider to correctly bill Cigna for the services you have received. It's important to inform your physician of the requirement to utilize an Cigna facility as a medical plan participant.

LEGAL NOTICES

FEDERAL LEGISLATION IMPACTING HEALTH CARE PLANS

Legislative Reminders Affecting Your Medical Plan

While our plans were already in compliance with these provisions, we are required to notify you of certain provisions on an annual basis. We would like to inform you of legislation that mandates coverage for you and your dependents. These benefits are included as part of your medical benefits to protect you and your family. No action is needed on your part.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide coverage for breast reconstruction, prostheses and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- » All stages of reconstruction of the breast on which the mastectomy has been performed.
- » Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- » Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient, and will be subject to the same annual Deductible, Coinsurance and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please call your plan administrator at (800) 521-2227.

Newborn and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

LEGAL NOTICES CONTINUED

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 March 17, 2026. Contact your State for more information on eligibility:

<p>ALABAMA – Medicaid</p>	<p>COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p>
<p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442</p>
<p>ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>	<p>FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
<p>ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>
<p>CALIFORNIA – Medicaid</p> <p>Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-445-8322</p>	<p>INDIANA – Medicaid</p> <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>

<p>IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>NEVADA – Medicaid</p> <p>Website: http://dhcnp.nv.gov Phone: 1-800-992-0900</p>
<p>LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p>MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 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</p>	<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>
<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-888-222-2542</p>
<p>OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p>VERMONT – Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p>PENNSYLVANIA – Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>
<p>RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>	<p>WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>

<p>SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>WEST VIRGINIA – Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p>TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p>WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since March 17, 2026, 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.

LEGAL NOTICES CONTINUED

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 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.

LEGAL NOTICES CONTINUED



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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.



LEGAL NOTICES CONTINUED

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.

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

[iHelp Tickets](#)

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.

LEGAL NOTICES CONTINUED

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

LEGAL NOTICES CONTINUED

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

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

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

LEGAL NOTICES CONTINUED

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 Uplift Education		4. Employer Identification Number (EIN) 75-2659683	
5. Employer address 3000 Pegasus Park Drive, Suite 1100		6. Employer phone number	
7. City Dallas	8. State TX	9. ZIP code 75247	
10. Who can we contact about employee health coverage at this job? Jessica O'Leary			
11. Phone number (if different from above) (469) 621-8500		12. Email address joleary@uplifteducation.org	

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

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

- Some employees. Eligible employees are:

PART-TIME EMPLOYEES - Employees working at least 10 hours but less than 30 hours per week are only eligible for medical insurance and do not qualify for the Uplift Education monthly cafeteria credit.
 EMPLOYEE ELIGIBILITY - New Hires have 30 days from their hire date to enroll in or decline benefits. All benefits are effective the first of the month following your hire date.

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

Determined by the insurance carriers and Texas Department of Insurance.

- We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.



**EMPLOYEE
BENEFITS GUIDE**
September 1, 2026 - August 31, 2027