

2026



Employee Benefits Enrollment Guide

August 1, 2026 – July 31, 2027

Introduction



Welcome!

Texas Select Staffing is committed to bring you the most comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work/life balance. We believe that we are providing a program that offers not only quality and value, but one that satisfies the diverse needs of our workforce.

This booklet serves as a great starting point to reference a summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), Summary Plan Description (SPD) and/or Plan Document for specific plan details. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Eligibility

Eligible Employee

All full-time employees and their dependents are eligible for benefits with Texas Select Staffing on the first of the month following 60 days after date of hire.

All employees must work a minimum of 30 hours per week to be considered full-time.

Eligible Dependent

You also have the option to enroll your eligible dependents which include:

- Your legal spouse
- Your children up to age 26 regardless of student or marital status

Enrollment



New Employee

You become eligible for medical, dental and vision benefits **on the first day of the month following 60 days after date of hire.**

Open Enrollment

You have the once-a-year opportunity to enroll in or make changes to your benefits during open enrollment. Employees who did not enroll at their initial eligibility period or who previously waived coverage for themselves and/or their dependents can take advantage of the open enrollment period to enroll in benefits for the upcoming plan year.

How to Enroll

Complete the 2026 Open Enrollment Election form. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status. **The plan year runs from August 1, 2026, through July 31, 2027.**

Changes During the Year

Changes to benefit elections cannot be made unless you experience a qualified life event. Qualified life events include, but are not limited to:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse, child, or qualified dependent
- Change in your residence that causes a change in the plans available to you
- Loss of dependent status (attainment of age 26)
- Involuntary loss of coverage due to change in employment status

You must contact HR within 30 days of the qualifying life event if you wish to change your benefit elections. Written documentation supporting your eligibility to make changes may be required.

Physicians

- Be sure to confirm on the insurance carrier's website and the physician's office that they are contracted and in-network with your insurance plan's network.
- Visiting in-network physicians and facilities lowers your out-of-pocket healthcare costs.

Pharmacy

- Make sure your pharmacy is in-network with your insurance prior to filling any prescriptions.
- Ask your physician if there is a generic alternative option to the prescription you are prescribed.
- Check with your insurance website on the cost of your prescription prior to going to the pharmacy.
- Research GoodRx, OneRx, or Cost-Plus Drugs for any discounts you may be able to apply.
- Visit the drug manufacturer's website for any savings that the manufacturer may offer.

Facilities

- Imaging services can be significantly lower costing at an independent imaging center than a hospital. Check your insurance's online provider directory for in-network imaging centers.
- ER visits can be extremely expensive. When you or a family member comes down with the flu or other minor ailments, see your family physician or urgent care facility rather than going to the emergency room. This can be more convenient but is must more expensive.
- Urgent Care Centers can act like an ER. Be sure the Urgent Care Center you visit confirms that they are truly Urgent Care and do not bill your insurance as an ER facility.

Medical Bills

- Assume every medical bill you receive is incorrect until it is proven correct with your insurance explanation of benefits (EOB).
- Anesthesia services are generally out-of-network with insurance companies. Be sure your anesthesia bill processed as in-network, and the anesthesia provider is billing you for what your insurance states.
- Always match the explanation of benefits (the document from your insurance) with the bill statement (the document from the medical provider) to ensure the bill is accurate.



Preventive Care

Preventive measures help with early detection! **Billions of dollars** in healthcare expenses can be prevented had the chronic illness been detected and treated early. If preventive care at the physician's office can cost hundreds of dollars to potentially save millions or billions, how important do you think getting your routine physical with lab work can be?

With that said, let's go over some of the common preventive care services that are covered at 100% through medical insurance and what to look out for while obtaining these tests:

Routine Physical Exam:

- This office visit is performed by a Primary Care Physician and is a visit to go over health matters to evaluate your overall health,
- It is important to note that, and medical issues discussed can change this visit from a routine visit to a diagnostic visit that will result in the patient paying for the office visit according to his/her insurance plan.
- Request your physician to bill this visit with a routine / preventive diagnosis code.

Routine Lab Work:

- Lab work is ordered by your physician in conjunction to a routine physical exam.
- It is important to note that not all the lab tests ordered by your physician are covered at 100%. Case in point; the Vitamin D test is one that physicians like to order in a routine physical exam. The Vitamin D lab test is no longer covered at 100% under preventive lab tests.
- You can request the names of the lab tests that the physician orders and call your insurance on the phone to confirm which test will be covered at 100% and which test will not be covered.

Well Woman Exam with Cervical Cancer Screening:

- Well Woman Exams are performed by the Obstetrics and Gynecologist (OB/Gyn).
- There is an age requirement set for this exam that coverage is 100% for women over the age of 21.
- While the exam portion (the office visit) may be covered at 100% once per year, the cervical cancer screening (pap smear), is recommended to be covered once every 3 years.
- Confirm with your insurance plan the frequency limit as this does change between each policy.

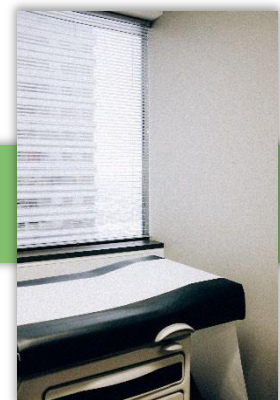
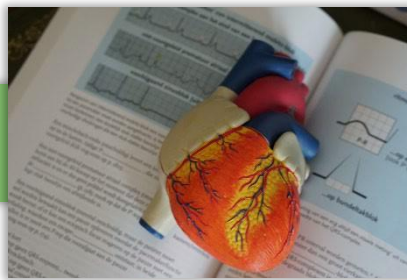
Routine Mammogram:

- This exam is ordered by your physician. It is important to request that the physician use a routine / preventive diagnosis code for this exam to qualify under your 100% preventive care coverage.
- There is an age limitation on this exam. Women must be at least 40 years old for a routine mammogram to be covered at 100%.
- Each insurance policy is different. Please check with your insurance to confirm the age limit and the frequency (once per year or once per two years).
- Please Note: If your physician orders another mammogram for a second opinion to the routine mammogram recently done, it will not be covered at 100% and will be subject to your deductible and/or coinsurance.

Preventive Colonoscopy:

- Gastroenterologists perform colonoscopies in an Endoscopy Center or a Hospital.
- A family history of colon cancer can change your preventive colonoscopy to a diagnostic colonoscopy leaving you with large medical bills.
- It is important to obtain the diagnosis code the physician plans to use and confirm with your insurance that the diagnosis code qualifies for 100% coverage.
- There are 3 medical providers that play a part in this procedure: the Gastroenterologist, the facility and the Anesthesiologist.
- If polyps are found during the routine colonoscopy, medical coding will reflect this and can alter the way insurance pays on the claim. However, this test should still be covered at 100% and correction of this with the insurance will be required.
- There is an age limit and frequency limit on preventive colonoscopies as well. The procedure will be covered at 100% for individuals over the age of 50 with a routine diagnosis.

While these are some of the most common routine / preventive tests, there are several other services that qualify as preventive services and can be found at, [U.S. Preventive Service Task Force's website](#). Please discuss with your physician about the medical necessity of the test and your insurance company to obtain how the service / test will be covered under your plan.



Medical Bill Review

Each time we receive medical care, whether that be at a doctor's office, urgent care center or at the hospital, we can expect to receive 2 documents: a bill statement from the medical provider and an explanation of benefits from the insurance carrier. These 2 documents are the starting point for us to review if the balance we owe is the correct balance we are to pay. Here are some helpful tips to help us review our medical bills.

Necessary Information To Obtain:

- 1) Provider Name
- 2) Date of Service
- 3) Total Charge
- 4) Patient Balance

The above 4 pieces of information should match on your medical bill statement and the explanation of benefits.

If they do not match, then we will need to review further as to why and what steps to take to resolve the issue. If they do match, it is also good practice to ask the following questions to ensure accuracy of the claim processing correctly towards your plan's benefits.

Questions To Ask:

- 1) Did the claim process towards the in-network benefits?
- 2) Were the correct insurance plan benefits applied to the medical service provided? In other words, should the service have been a copay or does the service apply towards the deductible?
- 3) Was this a preventive service that should be covered at 100% under the plan's benefits?
- 4) Does the total patient balance from all medical bills that we owe for the calendar year equal the exact amount of our deductible and/or our out-of-pocket maximum?

NorthShore
University Health System
PO BOX 0000 | ANYWHERE USA 12345-0000

Hospital/Clinic Statement

For help with billing questions, please call:
(555) 555-5555 or (555) 555-5555
Monday – Friday, 8:00am – 5:30pm
 Check if address/insurance changes are on back

Pay Online: northshore.mysecurebill.com
No Login Required!

Account Number	Due Date	Amount Due	Amount Paid
654321	11/10/2014	\$500.00	\$

Please make checks payable and remit to:

YOUR FACILITY
PO BOX 0000
ANYWHERE USA 12345-0000

Address: JON Q. DOE
1234 MAIN ST
ALBERT LEA, USA 56007

myEasy/Match Code: A-BCDEF-000000-GHIJKL

Account Number	Account Name	Statement Date	Due Date
654321	Jon Q. Doe	10/21/2014	11/10/2014

Date	Service Description	Status	Charges	Payments/Adjustments	Patient Balance
Hospital Charges					
PATIENT: JON Q. DOE Encounter #: 123456789 Loc: Highland Park Hospital Date of Service: 7/14/2014 to 7/31/2014 SPEECH THERAPY - LANGUAGE PATHOLOGY INSURANCE PAYMENT - BLUE CROSS PPO					
10/02/2014		Current	\$500.00	-\$250.00	\$250.00
Professional Charges					
PATIENT: JANE D. DOE Encounter #: 123456789 Provider: Aaron D. Friedman, MD					
10/01/2014	OFFICE/OUTPUT VISIT, EST, LEVL II		\$250.00		
10/01/2014	LARYNGOSCOPY, FLEX/RIGID+STROBOSCOPY		\$250.00		
10/02/2014	INSURANCE ADJUSTMENT - BLUE CROSS PPO			-\$100.00	
10/02/2014	INSURANCE PAYMENT - BLUE CROSS PPO			-\$150.00	
Patient Balance: Current \$250.00					
Total Statement Balance: \$500.00 Minimum Amount Due: \$500.00					



BenefitsTexas is here to help with your billing or claims questions! Call or email Debbie Allen at (972) 661-7216 or Debbie@BenefitsTexas.com.

It's important to know... where to go when you need to schedule laboratory services. Knowing your options and deciding where to go can mean the difference in cost and time. The main thing is to be prepared before you make sure ahead of time that your service will be covered by your plan's network.

Prescription costs can be difficult to determine.

Use the OneRx and GoodRx apps to find and help control costs of your prescribed medications. **See UHC website for drugs covered by your plan.**



OneRx allows you to upload your medical insurance ID card, so the app can check for the cost of prescriptions based on your current insurance Rx formulary.



GoodRx allows you to use manufacture coupons for your prescriptions and shows where to find the Rx at the lowest cost. When you use GoodRx you use the coupon not your insurance.



Cost Plus Drugs offers hundreds of common drugs at the lowest possible prices and shipped right to your door. We negotiate directly with manufacturers and pass all the savings directly to our patients.



Texas Select Staffing is offering two medical plans through UnitedHealthcare using two networks. **One plan uses the Charter HMO Network, and the other plan uses the Choice Plus PPO Network.** When you use the UnitedHealthcare network providers, your out-of-pocket expenses are kept to a minimum. When you use non-network providers, your out-of-pocket expenses are higher. For information on participating providers in your area, contact your Internal Service Representative at BenefitsTexas or go to www.myuhc.com.

The **UHC Choice Plus PPO** network is a Point of Service (POS) plan that offers a large national network of healthcare providers. Members can choose to receive care from in-network or out-of-network providers but will generally pay less for in-network services. POS plans typically require a referral from a Primary Care Physician (PCP) to see a specialist.

UnitedHealthcare **Charter HMO** plans are designed with savings in mind. By helping you build stronger connections with your Primary Care Physician (PCP), Charter works to help you make your health care experience better – and your health plan costs lower. The Charter plan is an HMO; therefore, you must stay IN Network for all benefits and go through your PCP for all specialist referrals. Please see page 15-16 in this booklet for more information.

For information about Medicare, please visit page 29 of this booklet.

Medical Plans



Plan Design	EIV3 CHARTER HMO	ETP2 CHOICE PLUS PPO	
	In-Network Coverage Only	In-Network	Out-of-Network
Deductible			
Individual	\$4,000	\$2,000	\$5,000
Family	\$8,000	\$4,000	\$10,000
Out-of-Pocket Max			
Individual	\$7,000	\$7,150	\$10,000
Family	\$14,000	\$14,300	\$20,000
Coinsurance			
What you pay after your Deductible has been met	0%	20%	50%
Preventive Visit	No Charge	No Charge	50% after Ded.
Virtual Visit	No Charge	No Charge	50% after Ded.
Primary Care Visit	\$10 Copay	\$15 Copay	50% after Ded.
Specialist Visit	\$60 Copay	\$50 / \$100 Copay	50% after Ded.
Urgent Care Visit	\$25 Copay	\$25 Copay	50% after Ded.
Emergency Room Visit	\$500 + Ded.	\$300 + 20% after Ded.	
Prescriptions (In-Network Retail / Mail Order)			
Tier 1	\$15 / \$37.50	\$15 / \$37.50	\$15 / N/A
Tier 2	\$45 / \$112.50	\$45 / \$112.50	\$45 / N/A
Tier 3	\$85 / \$212.50	\$85 / \$212.50	\$85 / NA

[Click HERE to find an In-Network pharmacy and the current 2025 Commercial Drug List.](#)

CVS is now considered an In-Network Pharmacy.

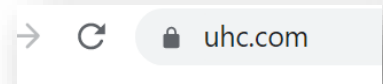
See Summary of Benefits and Coverage (SBC) for out-of-network coverage and more plan details. If a discrepancy is found between this overview and the SBC, the SBC will govern.

ENROLLING IN THE TEXAS-ONLY HMO?

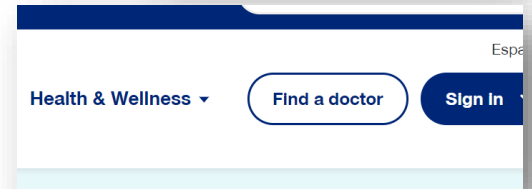
YOU ARE REQUIRED TO CHOOSE A PRIMARY CARE PHYSICIAN AT ENROLLMENT

HERE'S HOW TO FIND ONE...

1) VISIT WWW.UHC.COM



2) AT THE TOP OF THE PAGE, CLICK ON FIND A DOCTOR



3) SEARCH THE GENERAL PROVIDER LIST

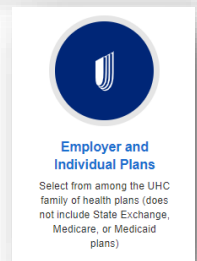
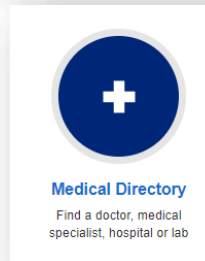
Search our general provider list

Start your search here if you're shopping for a plan or are unable to sign in to your member account. Choose your health plan name to get started.

[Start your search](#)

4) CHOOSE THE MEDICAL DIRECTORY

5) AND EMPLOYER/INDIVIDUAL PLANS



6) CHOOSE THE CHARTER/HMO NETWORK

Charter HMO / Charter Balanced HMO / Charter Plus HMO

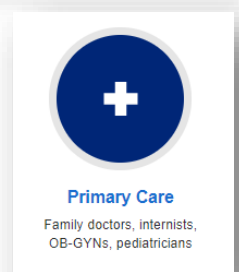
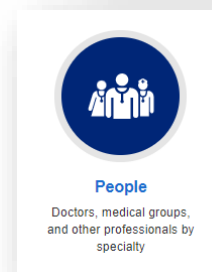
7) CHOOSE YOUR LOCATION

What type of Medical Care can we help you find near:

Carrollton, TX 75006

[Change Location >](#)

8) SEARCH PEOPLE THEN SEARCH PRIMARY CARE



9) SEARCH ALL PRIMARY CARE

Which type of primary care provider (PCP)?

All Primary Care Providers

The first person you call when you have a medical concern. Primary care providers can be doctors in family practice, internal medicine, pediatrics or other specialties.

10) PICK A DOCTOR YOU LIKE FROM THE LIST



Cardenas, Edgar Alejandro, MD
Family Practice, General Practice

9991 Marsh Ln Ste 100
Dallas, TX 75220
6.1 Miles Away | [Get Directions](#)

(214) 358-0090 Phone
711 TTY

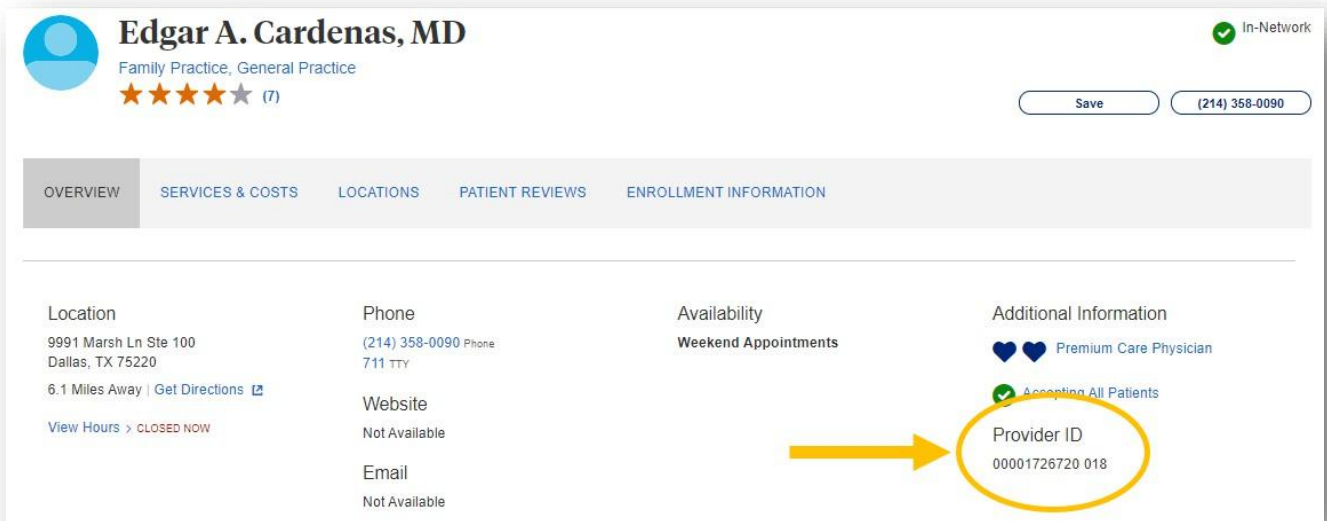
[Additional Locations \(3\)](#)

♥♥ Premium Care Physician
✔ Accepting All Patients
✔ In-Network Provider

★ ★ ★ ★ ★ (7)

You May Owe
*N/A
[Login To View Costs](#)

11) CLICK ON DOCTOR'S NAME TO FIND YOUR PROVIDER'S ID NUMBER



Edgar A. Cardenas, MD
Family Practice, General Practice
★ ★ ★ ★ ★ (7)
In-Network

[Save](#) [\(214\) 358-0090](#)

OVERVIEW SERVICES & COSTS LOCATIONS PATIENT REVIEWS ENROLLMENT INFORMATION

Location
9991 Marsh Ln Ste 100
Dallas, TX 75220
6.1 Miles Away | [Get Directions](#)
[View Hours](#) > CLOSED NOW

Phone
(214) 358-0090 Phone
711 TTY

Website
Not Available

Email
Not Available

Availability
Weekend Appointments

Additional Information
♥♥ Premium Care Physician
✔ Accepting All Patients

Provider ID
00001726720 018

YOU MAY ASK UNITED HEALTHCARE TO CHANGE YOUR PCP AS OFTEN AS ONCE PER MONTH, BUT YOU MUST ALWAYS HAVE A PCP AS YOUR GO-TO PRPVIDER...AND YOU MUST CHOOSE A PROVIDER TO ENROLL.

PLEASE CONTACT YOUR HUMAN RESOURCES TEAM FOR QUESTIONS.



Important things to know about selecting your PCP

A primary care provider (PCP) is your health guide—someone who can help coordinate your care and supports you in achieving your best health.

Your PCP:

- Must be a general practice, family practice, pediatrician or internal medicine provider*
- Must be an individual provider, not a medical practice**
- Must be accepting new patients (if you are not a current patient)
- Must be located in a town or city near where you (the subscriber) live or work
- Can be selected for the entire family or each covered member can select their own



A PCP is the doctor who knows you best—who understands your health history and health goals. They're who you turn to first—for everything from routine care to prescriptions and more.

And, since most PCPs offer virtual visits for primary care, you can choose to see them in person or from home.

So, whether or not your plan requires you to have a PCP, it's a good idea to choose one.

See reverse side for instructions on how to select a PCP.

*Some states allow you to choose a specialist, like an OB/GYN, as your PCP. Contact your employer for more information.

**Some health plans may allow you to choose a medical group rather than a doctor as your PCP.

continued

Follow these steps to choose your PCP

- 1 • Go to myuhc.com® (you don't need to sign in)
• Then select **Find a Provider > Medical Directory** then, **Employer and Individual Plans**.

Not sure which plan name to look for? Check your open enrollment materials or ask your employer.

- 2 If prompted, select the year in which you will be receiving care (choose the following year if you are making open enrollment selections)—confirm the ZIP code for your search, choose **People**, then **Primary Care**, then select from any of the categories listed.

John Smith, MD
Family Practice
★★★★★ (27) In-Network

Save (555) 555-1234

OVERVIEW SERVICES & COSTS **LOCATIONS** PATIENT REVIEWS

2 Locations for 12345

ADJUST RADIUS
Within 20 Miles

Location	Phone	Availability	Additional Information
1234 Main Street, Ste 123 Anytown, ST 12345 4 Miles Away Get Directions View Hours > OPEN NOW	(555) 555-1234 Phone 123 TTY Website Not Available Email Not Available	Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years	Premium Care Physician Accepting All Patients Provider ID 01234567891234 Copy
1010 North Hwy, Ste 100 Othertown, ST 12345 7 Miles Away Get Directions View Hours > OPEN NOW	(555) 555-5555 Phone 456 TTY Website Not Available Email Not Available	Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years	Premium Care Physician Accepting All Patients Provider ID 43219876543210 Copy

- 3 Scroll through the search results, and once you have made your selection, click on the provider's name to **locate the Provider ID in the lower right corner of the page**. Select **Copy** or write it down—you'll need it when you enroll.

- 4 If your selected PCP is associated with multiple locations, you can find the correct Provider ID by selecting **Locations** and then copying the appropriate Provider ID.

And there you have it—choosing your PCP is the first step in the process to help manage your health. Be sure to schedule your first visit with your PCP. It can be a great way for your doctor to get to know you—and vice versa.

Questions?

For enrollment support please call **1-866-873-3903** or visit www.myuhc.com

United Healthcare

This Guide is intended for individuals selecting a new plan (or) in open enrollment. Active members should log in to myuhc.com for assistance.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

UnitedHealthcare Level Funded: Administrative services provided by UnitedHealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Stop Loss only: Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company of New York (in NY) and UnitedHealthcare Insurance Company (in all other states and DC).

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthCare Services, Inc. or their affiliates.

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Get more out of your health plan benefits with these 2 handy digital tools



The UnitedHealthcare® app and myuhc.com®

Whether on the go or online, you'll have access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Quickly compare cost estimates before you get care
- Learn about covered preventive care
- Access your health plan ID card and add your plan details to your smartphone's digital wallet

Register once to access both tools

Start by downloading the UnitedHealthcare app or going to myuhc.com and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication—then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now you're registered for—and connected to—the app and the website.

Get connected



Scan this code to download the app and register, or visit myuhc.com

United Healthcare

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section. Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits. The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Health Plan coverage provided by or through a UnitedHealthcare company. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Good care starts with good information.



Remembering the medications you've been prescribed, procedures you've had and conditions you've been treated for isn't always easy. With the new Individual Health Record feature on myuhc.com[®] and the UnitedHealthcare[®] app, you don't have to.

Discussing your health history just got easier.

Your Individual Health Record puts over a year's worth of history—from all of your providers*—in the palm of your hand. So now, each time you visit a doctor, you can bring it along to help ensure they have a better picture of your overall health.

One place provides access to your:



Allergies



Care Team



Conditions



Immunizations



Prescriptions



Procedures



View your health history on the spot:

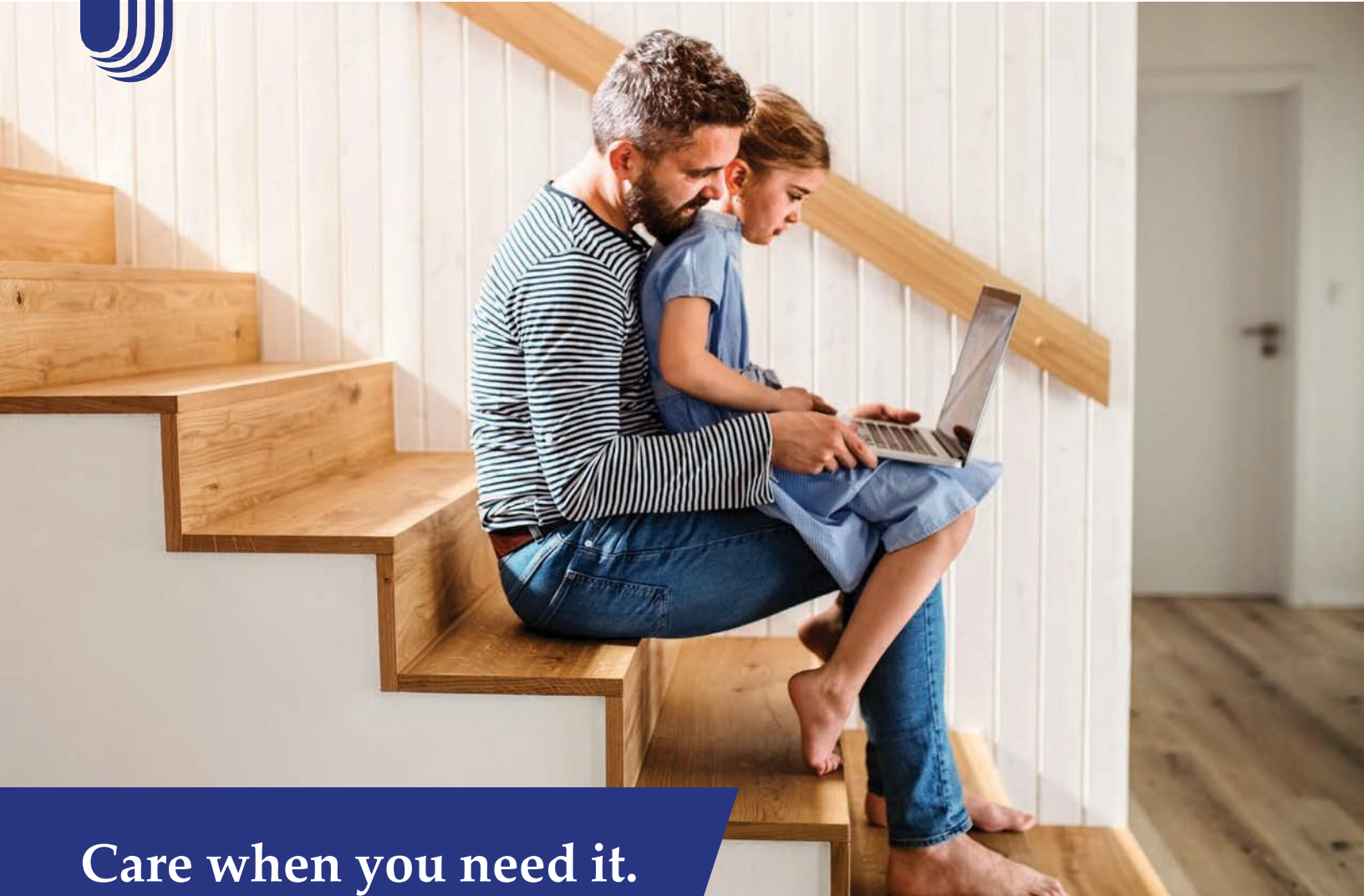
- Go to myuhc.com > Account/Profile > Individual Health Record.
- Go to UnitedHealthcare app > Menu Icon > Individual Health Record.

*Individual Health Record only applies to care you've received as a UnitedHealthcare member, so newer members will have less history.

Your Individual Health Record only has information on care you've received as a UnitedHealthcare member during a certain time frame. Information in the Individual Health Record is not a substitute for medical or behavioral health care advice. If you have questions about information in your Individual Health Record, please talk with your doctor or call the IHR Dedicated Service Team toll-free at 1-844-585-1471. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

Facebook.com/UnitedHealthcare Twitter.com/UHC Instagram.com/UnitedHealthcare YouTube.com/UnitedHealthcare

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Care when you need it. No shoes required.

You can make a virtual care appointment for your urgent care, primary care, mental health and specialty care needs. You may get seen faster by a provider and often, it even costs less. All from the comfort of anywhere you choose.

Get seen sooner with virtual care

On average, you can connect with a provider by video or phone* in:

15 minutes or less**
for 24/7 Virtual Visits

3 days or less
for virtual specialty care

1 week or less
for virtual primary care
or virtual therapy

*Data rates may apply.

**Based on 2023-2024 analysis of provider average wait times from request to visit across UnitedHealthcare Designated Virtual Network Providers. Wait times may be impacted by volume at time of the visit.

continued

Let care come to you

Here are some of the things virtual care can help you with.

24/7 Virtual Visits

- Bronchitis
- Coughs, colds and flu
- Fevers
- Headaches
- Pinkeye
- Rashes
- Sinus problems
- Stomach pain and urinary tract infections (UTIs)

Virtual primary care

- Annual wellness visits, covered 100% just like in-person
- Lab orders
- Non-urgent needs
- Prescription refills*
- Specialist referrals

Virtual therapy

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Grief
- Mental health disorders
- Stress

Virtual specialty care

- Dental care
- Dermatology
- Gastroenterology needs
- Migraines
- Sleep apnea
- Speech therapy
- Women's health issues, like menopause, birth control and breast health



Make an appointment

Scan or visit myuhc.com/virtualcare to get started

**United
Healthcare®**

*Certain prescriptions may not be available, and other restrictions may apply.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Virtual primary care are services available with a provider via video, chat, email, or audio-only where permitted under state law. Virtual primary care services are only available if the provider is licensed in the state that the member is located at the time of the appointment. Virtual primary care is not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Certain prescriptions may not be available, and other restrictions may apply.

Virtual Specialists are services available with a provider or coach via video, chat, email, or audio-only where permitted under state law. It is not an insurance product or a health plan. Virtual Specialists are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Certain prescriptions may not be available, and other restrictions may apply.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.



Using your pharmacy benefits

Optum Rx® is your plan's pharmacy services manager and is committed to helping you find cost-effective ways to get your medications.

Set up your online account

Once registered on myuhc.com®, access the pharmacy section to:

- Manage your home delivery medications
- Set up email or text message¹ reminders
- Check your home delivery status

Use the UnitedHealthcare app

Manage your prescription benefit and home delivery orders with the UnitedHealthcare® app on your smartphone or tablet.

Use a network pharmacy

Be sure to fill your prescriptions at a network pharmacy, otherwise they may not be covered or you may pay more.² Finding a network pharmacy is easy:

- Log in to myuhc.com
- Or use the UnitedHealthcare app
- Or call the number on your health plan ID card

Home delivery from Optum

Consider using Optum® Home Delivery to help manage the medications you take regularly. Home delivery is reliable and offers the following advantages:



Cost savings

You may pay less for your medication with a 3-month supply.



Convenience

Get free standard shipping.



24/7 access and reminders

Speak to a pharmacist any time, any day. Set up medication reminders.

You may be able to refill your home delivery prescriptions automatically through the Automatic Refill program.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery.

How to choose home delivery

By going online:

Visit myuhc.com, register and follow the simple step-by-step instructions.

By phone:

Call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available.

By ePrescribe:

Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.*

*This update does not apply to providers in Alaska, Guam, Puerto Rico or the U.S. Virgin Islands.

Making medication decisions

Use the UnitedHealthcare prescription drug list (PDL)

The PDL is a list of your plan's covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

Cost tier	Includes	Helpful tips
\$ Tier 1 — Lowest cost	Lower-cost medications. Some brand-name medications.	In most cases, Tier 1 medications have the lowest cost. Consider generic options which may also help you save.
\$\$ Tier 2 — Mid-range cost	Mix of brand-name and generic medications.	Tier 2 drugs may cost less than Tier 3 drugs. ³
\$\$\$ Tier 3 — Highest cost	Highest-cost brand-name medications and some generic medications.	Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you. ³

*Some Connecticut plans have a 4th tier that includes higher cost brand-name and generic medications, as well as non-preferred brand-name and specialty medications.

Save money

In most cases, generic medications have a lower copay than brand-name medications. Ask your doctor if there is a generic alternative for you.

Compare prices

Search for lower-cost alternatives. Just log in to myuhc.com. Or use the UnitedHealthcare app.



Tips



Know your plan

Your plan may require one or more of the following for your prescription to be covered:

Prior authorization: approval to get a medication.

Step therapy (First Start for NJ plans only): trying one medication before another.

Quantity limits: only a certain amount of the medication is allowed for coverage.

Log on to myuhc.com to see if you could save. Or use the UnitedHealthcare app.



Talk to your doctor

When you talk with your doctor, use the UnitedHealthcare app to confirm coverage and costs. You can also talk about what you need to do to get your medication.



Optum Specialty Pharmacy

At Optum® Specialty Pharmacy, we offer the resources, programs and clinical support you need to manage your specialty medications with confidence.

Your plan may also include

Your plan **may include** the cost-saving medication home delivery program below. With each of these programs, you are allowed a limited number of refills at your current pharmacy. Then you must take action.

Mail Service Saver

Switch to Optum Home Delivery or you may pay more.

Mail Service Saver Plus

Switch to Optum Home Delivery or you will pay the full price for your medication.



Get in on UHC Rewards



Good news—your health plan comes with a new way to earn up to \$300. UnitedHealthcare Rewards is included in your health plan at no additional cost.



There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. The activities you go for are up to you—same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you—and look for new ways of earning rewards to be added throughout the year.

Earn up to
\$300

United
Healthcare

There are 2 ways to get started



On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Menu** tab and choose **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning



Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to \$300 and use it however you want

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable. This program is not available in Hawaii, Kansas, Vermont and Puerto Rico. Components subject to change.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

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Dental Plan

Research shows a potential link between periodontal disease and other health problems such as heart disease, stroke, diabetes control and premature birth. Your UnitedHealthcare Dental plan helps you to receive this important care at a reasonable price. The PPO plan allows participants to select the dentist of their choice regardless of whether the provider is contracted with **UnitedHealthcare**. Your total out-of-pocket payment will be higher if you visit someone not associated with the network. All in-network dentists have agreed to accept an allowable amount, as determined by UnitedHealthcare as payment in full and cannot bill you for more than the applicable co-payments, coinsurance and deductibles for the services provided.



Dental Plan OP054 / UCR90

Annual Maximum Benefit (per person per calendar year)	\$1000
CALENDAR YEAR DEDUCTIBLE (waived for preventive services)	
Per Covered Person	\$50
Family Maximum	\$150
COINSURANCE LEVEL (what UHC pays for each category of service)	
Diagnostic & Preventive Services includes periodic oral evaluation (2 per year), cleanings (2 per year), fluoride treatments, bitewing x-rays, sealants, space maintainers, lab & other diagnostic tests	100%
Basic Services include restorations, emergency treatment, occlusal guards, anesthesia, palliative treatment, simple extractions	80%

Major Services includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exists, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for services rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

See Summary of Benefits and Coverage (SBC) for out-of-network coverage and more plan details. If a discrepancy is found between this overview and the SBC, the SBC will govern.

Visit www.dentaltx.uhc.com to find a dentist or call (877) 901-7321

UnitedHealthcare ID Cards

When you sign up for health insurance, your health plan will send a member identification (ID) card to you and your covered family members. Your member ID card (or health plan ID card) is proof that you have health insurance. Health care providers use the information from your member ID card to confirm they are part of your plan's network and to bill your health plan for your care. Some plans have mobile apps that let you share the member ID card on your smartphone or tablet. Keep your member ID card handy when you:

- Go to the doctor
- Go to the hospital
- Have lab work done
- Get a prescription filled (if your plan has drug coverage)

You can also view your member ID card using the UnitedHealthcare app. Use your mobile device to download the app.



Need More Help?

At BenefitsTexas, Inc., exceptional service starts with exceptional resources. Below are contacts for dedicated Employee Benefit Specialists to assist you with every aspect of your comprehensive employee benefits.

Please feel free to reach out to us for assistance between the hours of 7:30AM and 4:00PM Monday through Friday!

Benefits, Claims, and Prescription Assistance

- Is my doctor/dentist In-Network or Out-of-Network?
- What is my deductible and what does "co-insurance" mean?
- I received a bill from my doctor. Was my claim paid correctly?
- What is an "EOB" and how do I read it?
- I paid for my prescription out-of-pocket. Where can I obtain a claim form?
- My company changed medical plans. Will my prescription still be covered for the same price?

Any Other Matters

- I have not received my ID cards. Can I get new ones?
- I cannot find my Benefit Enrollment Guide; may I get a new one?
- Can someone help me understand the benefits offered to me?

If you do not see your question listed above, that means you should contact us today to help you! Please feel free to reach out to us at the contact information listed below.

Debbie Allen

INTERNAL SERVICE REPRESENTATIVE

Phone: 972-663-7216 or 877-918-3348

Fax: 972-663-7362

Email: debbie@BenefitsTexas.com

Availability: Monday-Friday
7:30AM-4:00PM

Important Contacts

Questions Regarding	Company	Contact Information
Claims & Benefit Questions	BenefitsTexas Debbie Allen	(972) 663-7216 Debbie@benefitstexas.com
Medical	UnitedHealthcare Policy #1749720	(866) 801-4409 www.myuhc.com Memberservices_uhccp@uhc.com
Dental	UnitedHealthcare Policy #1749720	(877) 901-7321 www.dentalx.uhc.com

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 Texas, you may be eligible for assistance paying your employer health plan premiums. The following is current as of March 17, 2025. Contact your State for more information on eligibility.

TEXAS – Medicaid
Website: Texas Health & Human Services
Phone: (800) 440-0493
For a list of additional states, contact stephanie@benefitstexas.com

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

US Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
(866) 444-3272
Menu Option 4, Ext. 61565

US Department of Health & Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323

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.

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Annual Notice

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

HIPAA Special Enrollment Notice

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

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

Eligible employees and dependents may also enroll under two additional circumstances:

1. the employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated because of loss of eligibility; or
2. the employee or dependent becomes eligible for a subsidy (state premium assistance program)

The employee or dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Medical Disclaimer for Medicare

When you or any of your dependents are a member of an Employer Plan and you also are eligible for Medicare, your benefit carrier will apply the terms of the Employer Plan along with rule and regulations of Medicare in determining whether Medicare or your Employer Plan will be the Primary Plan. In general, under Medicare, working status and group size – the number of employees covered under the Employer Plan – determine when Medicare is Primary. The Employer Plan is primary for people who are 65 or older, still working for an employer with 20 or more employees and eligible for Medicare.

If the employer has fewer than 20 employees, Medicare is Primary. If you are enrolled in Medicare OR eligible for Medicare *but are not enrolled in Parts A and B*, your claim will be processed with the plan carrier as Secondary Coverage.

If you retire, are eligible for Medicare and retain your coverage under your Employer Plan, Medicare is Primary. Other COB (Coordination of Benefits) rules for Medicare apply if you are disabled and covered by a large Employer Benefit Plan or are covered under COBRA continuation benefits. If you are eligible for Medicare because you are disabled, or eligible for any reason other than age, please contact your plan administrator, the claims administrator or Medicare for information about specific Medicare rules that apply to your circumstances.

See Summary of Benefits and Coverage (SBC) for out-of-network coverage and more plan details. If a discrepancy is found between this overview and the SBC, the SBC will govern.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. **This is not a plan document.** The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

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Have you contacted your ISR lately?

At BenefitsTexas, Inc. you have a dedicated ISR (Internal Service Representative) to assist you with your benefit offerings. Your ISR is a valuable and helpful resource who will assist you with questions including....

- ✓ **How do I order a new ID card?**
- ✓ **Is my doctor In-Network or Out-of-Network?**
- ✓ **What is my deductible and what does “co-insurance” mean?**
- ✓ **I received a bill from my doctor. Was my claim paid correctly?**
- ✓ **What is an “EOB” (Explanation of Benefits) and how do I read it?**
- ✓ **How does the pediatric dental coverage through my medical plan work?**
- ✓ **Are there discounts for eye glasses/contacts through my medical plan?**
- ✓ **I paid for my prescription out-of-pocket. Where can I obtain a claim form?**
- ✓ **Is there a generic drug available for my prescription?**
- ✓ **Do I need to obtain pre-authorization for a recommended treatment?**

Reminder, you have the opportunity to contact your **BenefitsTexas** ISR for many of your benefit questions **Monday – Thursday, from 7:30 am – 4:00 pm, Friday 7:30-2:00pm.**

ID Card, Change of address

Melissa Morrison
Internal Service Representative
Melissa@benefitstexas.com
Direct # 214-226-3203

Claims and Benefit Questions

Debbie Allen
Internal Service Representative
debbie@benefitstexas.com
Direct # 972-663-7216





New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact 214.389.5600

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

¹ An employer-sponsored 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.

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 Texas Select Staffing		4. Employer Identification Number (EIN) 27-0919516	
5. Employer address 801 N. Goliad Street		6. Employer phone number 214.389.5600	
7. City Rockwall	8. State TX	9. ZIP code 75087	
10. Who can we contact about employee health coverage at this job? Your assigned recruiter			
11. Phone number (if different from above) 214.389.5600		12. Email address info@texasselectstaffing.com	

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

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

All employees. Eligible employees are:

See for all info: <https://www.texasselectstaffing.com/insurance/>

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

See for all info: <https://www.texasselectstaffing.com/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.

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

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

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

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

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)