PAY AND SAVE, INC.

2026 TEAMMATE BENEFITS GUIDE

WELCOME

We are pleased to offer you a comprehensive benefits program intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits available to you and your eligible dependents.

To get the best value from your benefits program, please take the time to evaluate your coverage options and determine which plans best meet the health care and financial needs of you and your family. By being a wise consumer, you can support your health and maximize your health care dollars.

Each year, you have the opportunity to make changes to your benefits plans. The enrollment decisions you make this year will remain in effect through December 31, 2026. After your initial eligibility period, you may make changes to your benefit elections only when you have a Qualifying Life Event. You will have 30 days to make your benefits elections and submit supporting documentation to Human Resources. If you do not make your changes during the 30-day period, your changes cannot be made until the next Open Enrollment period.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Your benefits program offers one medical plan coverage option. A Summary of Benefits and Coverage (SBC) is available by visiting **https://lowespayandsavebenefits.com/**.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 16 for more details.

ELIGIBILITY

You are eligible for benefits if you are a regular, full-time teammate working an average of 32 hours per week. Your coverage is effective the first of the month after you have completed 60 days of full-time employment. You may also enroll eligible dependents for benefits coverage. The cost to you for dependent coverage depends on the number of dependents you enroll and the particular plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself. **You must enroll in the Pay and Save, Inc. BCBSTX medical plan to be eligible to enroll in any of the other benefits.**

ELIGIBLE DEPENDENTS INCLUDE

- Your legal spouse
- Children under the age of 26 regardless of student, dependency, or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

QUALIFYING LIFE EVENTS

Once you elect your benefits options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, and you must do so within 30 days of the event.

QUALIFYING LIFE EVENTS INCLUDE

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of a spouse or child
- Change in your spouse's employment that affects benefits eligibility
- Change in your child's eligibility for benefits (e.g., reaching the age limit)
- Change in residence that affects your eligibility for coverage
- Significant change in benefit plans coverage or cost for you, your spouse, or your child
- FMLA leave of absence, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order

If you have a Qualifying Life Event and want to request a midyear change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

MEDICAL BENEFITS

The medical plan through **Blue Cross Blue Shield of Texas (BCBSTX)** is designed to protect you and your family from major financial hardship in the event of illness or injury.

PREFERRED PROVIDER ORGANIZATION

The Preferred Provider Organization (PPO) plan allows you the freedom to see any provider when you need care. When you use in-network providers, you receive benefits at a discounted network cost. You may pay more for services if you use out-of-network providers. In-network preventive care and MDLIVE telemedicine visits are covered at 100%. In-network office visits, urgent care visits, emergency care, and pharmacy costs are covered with a copay. Most other services are covered at the coinsurance level after your deductible has been met.

To find a list of in-network providers, visit **www.bcbstx.com** or call **800-521-2227**.

NOTE

You must be enrolled in the BCBSTX medical plan to be eligible for the MDLIVE benefit. Marriage and/or birth certificates must be provided. Proof of eligibility (marriage and/or birth certificates) must be provided.

MDLIVE

Pay and Save, Inc. partners with **MDLIVE** to provide 24/7/365 access to U.S. board-certified doctors through the convenience of a phone call. MDLIVE is an alternative to urgent care and emergency room visits. While it does not replace your primary care physician, MDLIVE is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an urgent care clinic or emergency room for treatment
- Are on a business trip, vacation, or are away from home
- Your primary care physician is unavailable

24/7 access to a PHYSICIAN

888-680-8646

Speak with an in-network physician regarding common conditions, such as allergies, respiratory infections, urinary tract infections, cold or flu symptoms, and more!

All covered teammates eligible.
Included with BCBSTX plan coverage.

GET THE CARE YOU NEED

MDLIVE doctors can treat many medical conditions or provide assistance with:

- Cold and flu symptoms
- Headaches
- Stomachaches
- Allergies
- Fevers
- Urinary tract infections
- Anxiety and depression
- Child behavior and learning issues
- Relationship issues

Register online at **www.mdlive.com/bcbstx** so you are ready to use this valuable service when and where you need it. Once you are registered, call **888-680-8646** to speak with a doctor or health service specialist anytime.

Check Out the "Meat and Potatoes" of Medical Benefits We Have in Stock!

MEDICAL BENEFITS SUMMARY

BCBSTX PPO		
	IN-NETWORK	**OUT-OF-NETWORK**
Calendar Year Deductible • Individual • Family	 $2,500 $7,500	 $7,500 $21,500
Calendar Year Out-of-Pocket Maximum Includes deductible and copayments • Individual • Family • Lifetime Maximum	 $5,000 $14,700 Unlimited	 $15,000 $30,000 Unlimited
	YOU PAY	**YOU PAY**
Preventive Care	$0	70% after deductible
MDLIVE/Telemedicine	$0	70% after deductible
Primary Care Physician	$45 copay	70% after deductible
Specialist	$60 copay	70% after deductible
Diagnostics X-ray and Lab	$0	70% after deductible
Complex Imaging	30% after deductible	70% after deductible
Urgent Care	$100 copay	70% after deductible
Emergency Room/Treatment Room	30% after $250 copay	30% after $250 copay
Inpatient Hospital Care	30% after deductible	70% after deductible
Outpatient Surgery	30% after deductible	70% after deductible
PHARMACY		
RETAIL RX (UP TO 30-DAY SUPPLY)		
Generic	$15 copay	20% minus copay
Preferred Brand Name	$30 copay	20% minus copay
Non-preferred Brand Name	$45 copay	20% minus copay
Specialty	$150 copay	20% minus copay
MAIL ORDER RX (UP TO 90-DAY SUPPLY)		
Generic	$75 copay	N/A
Preferred Brand Name	$150 copay	N/A
Non-preferred Brand Name	$200 copay	N/A

DENTAL PLAN

Our dental plan helps you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **BCBSTX**.

DENTAL PPO PLAN

Two levels of benefits are available with the Dental PPO (DPPO) plan: in-network and out-of-network. You may select the dental provider of your choice, but your level of coverage may vary based on the provider you see for services. Using an in-network provider will provide you with the highest level of benefits and the deepest discounts the plan offers. You could pay more if you use an out-of-network provider.

FIND AN IN-NETWORK DENTIST

Visit **www.bcbstx.com** or call **800-521-2227**.

NOTE

You must be enrolled in the BCBSTX medical plan to be eligible to enroll in these benefits. Proof of eligibility (marriage and/or birth certificates) must be provided.

DENTAL BENEFITS SUMMARY

DENTAL PLAN		
	IN-NETWORK	OUT-OF-NETWORK*
Calendar Year Deductible • Individual • Family	 $50 $150	 $50 $150
Calendar Year Benefit Maximum Per Individual	$1,000	
	YOU PAY	YOU PAY
Preventive and Diagnostic Care Exams, cleanings, X-rays, fluoride treatments, sealants, space maintainers	$0	$0
Basic Care Fillings, simple extractions, oral surgery, endodontics, periodontics, repairs of bridges, crowns and inlays, anesthesia	20% after deductible	20% after deductible
Major Restorative Care Implants, crowns, dentures, bridges, inlays, onlays	50% after deductible	50% after deductible

*If you use an out-of-network provider, services will be paid based on the Reasonable and Customary (R&C) amount for your area as determined by BCBSTX. If your dentist's fee is lower than the R&C fee, the plan pays benefits based on the actual fee. If the fee is higher, the plan pays benefits based only on the R&C fee, and you pay the difference. Pretreatment review is highly recommended if proposed dental treatment is more than $300.

VISION PLAN

The **VSP** vision plan is designed to meet your basic eyewear needs and preserve your health and eyesight. In addition to identifying vision and eye problems, regular exams can detect certain medical issues such as diabetes or high cholesterol. You may seek care from any licensed optometrist, ophthalmologist, or optician, but plan benefits are better if you use an in-network provider. The vision plan uses VSP's **PPO Vision** network of providers.

FIND AN IN-NETWORK VISION PROVIDER

Visit **www.vsp.com** or call **800-877-7195**.

NOTE

You must be enrolled in the BCBSTX medical plan to be eligible to enroll in these benefits. Proof of eligibility (marriage and/or birth certificates) must be provided.

VISION BENEFITS SUMMARY

VISION PLAN		
	IN-NETWORK YOU PAY	**OUT-OF-NETWORK REIMBURSEMENT UP TO**
Exam	$20 copay	$45
Retinal Imaging	Up to a $39 copay	Not covered
Lenses ◆ Single Vision ◆ Bifocals ◆ Trifocals	 $20 copay $20 copay $20 copay	 $30 $50 $65
Frames	80% of balance over $200 allowance	$70
Contacts In lieu of frames and lenses ◆ Fitting and Evaluation ◆ Elective ◆ Medically Necessary	 Up to a $60 copay $150 allowance $20 copay	 Not covered $105 $210
BENEFIT FREQUENCY		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts	Once every 12 months	

LIFE AND AD&D INSURANCE

Life and Accidental Death and Dismemberment (AD&D) insurance are important parts of your financial security, especially if others depend on you for support. With Life insurance, your beneficiary(ies) can use the coverage to pay off your debts, such as credit cards, mortgages, and other final expenses. AD&D coverage provides specified benefits for a covered accidental bodily injury that causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

BASIC LIFE AND AD&D INSURANCE

Basic Life and AD&D insurance are provided by Pay and Save, Inc. at no cost to you through **BCBSTX**. You are automatically covered for $10,000.

VOLUNTARY LIFE AND AD&D INSURANCE

You may purchase additional Life and AD&D insurance for you and your eligible dependents. If you decline Voluntary Life and AD&D insurance when first eligible, or if you elect coverage and wish to increase your benefit amount at a later date, proof of good health may be required before coverage is approved.

You must elect Voluntary Life and AD&D insurance for yourself in order to elect coverage for your spouse or children. Coverage is provided through **BCBSTX**. If you leave Pay and Save, Inc., you may be able to take the insurance with you.

VOLUNTARY LIFE AND AD&D	
COVERAGE FOR	**AVAILABLE COVERAGE**
Teammate	• Increments of $10,000 up to the lesser of five times your annual salary or $500,000 • Guaranteed Issue $200,000
Spouse	• Increments of $5,000 up to $100,000 not to exceed 50% of teammate coverage • Guaranteed Issue $25,000
Unmarried Dependent Child(ren)	• $5,000 or $10,000 not to exceed either parent's benefit amount • $500 for children under six months • Guaranteed Issue $10,000

DESIGNATING A BENEFICIARY

A beneficiary is the person or entity you designate to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries anytime. If you name more than one beneficiary, you must identify the share for each.

VOLUNTARY LIFE MONTHLY RATES PER $1,000			
TEAMMATE AND SPOUSE			
AGE	**RATE**	**AGE**	**RATE**
<29	$0.121	**50-54**	$0.335
29-34	$0.146	**55-59**	$0.586
35-39	$0.159	**60-64**	$0.876
40-44	$0.172	**65-69**	$1.642
45-49	$0.234	**70+**	$2.635
CHILDREN			
AMOUNT	**RATE**	**AMOUNT**	**RATE**
$5,000	$0.76	**$10,000**	$1.52

VOLUNTARY AD&D MONTHLY RATES PER $1,000	
Teammate	$0.021
Dependent(s)	$0.028

Calculation Example

Teammate age 35 elects $50,000 in Life coverage.

BENEFIT AMOUNT $50,000

÷ 1,000 . . . . . ÷ 1,000

= BENEFIT FACTOR . . . . . = 50

× AGE-BASED RATE . . . . . × $0.159

= MONTHLY PREMIUM . . . . . = $7.95

× 12 Months . . . . . × 12

= Yearly Cost. . . . . = $95.40

÷ 52 Weeks . . . . . ÷ 52

= Weekly Payroll Deduction . . . . . = $1.83

SUPPLEMENTAL COVERAGE

Fixed indemnity policies may pay you a limited dollar amount if you are sick or hospitalized. You are still responsible for paying the cost of your care.

- The payment you get is not based on the size of your medical bill.
- There might be a limit on how much a policy will pay each year.
- A policy is not a substitute for comprehensive health insurance.
- Since a policy is not health insurance, it does not have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit **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 a policy?

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

Important: This benefits package includes fixed indemnity policies, which are not health insurance. Please see supplemental benefits on pages 10-13 for more details.

UNUM COVERAGES

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Long Term Disability (LTD) insurance for you to purchase through **Unum**.

VOLUNTARY LONG TERM DISABILITY

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to Social Security Normal Retirement Age (SSNRA).

VOLUNTARY LONG TERM DISABILITY	
Benefits Begin	91st day
Percentage of Earnings You Receive	60%
Maximum Monthly Benefit	$6,000
Maximum Benefit Period	SSNRA
Pre-existing Condition Exclusion	12/12*

*Benefits may not be paid for any condition treated within 12 months prior to your effective date until you have been covered under this plan for 12 months.

AGE	RATE PER $100 COVERED PAYROLL
<25	$0.29
25-29	$0.36
30-34	$0.47
35-39	$0.62
40-44	$0.78
45-49	$1.02
50-54	$1.17
55-59	$1.34
60+	$1.40

EMPLOYEE ASSISTANCE PROGRAM

Pay and Save, Inc. provides an Employee Assistance Program (EAP) to help you and family members cope with a variety of personal or work-related issues. As part of your LTD coverage through **Unum**, you can get confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work-life balance
- Stress and anxiety
- Grief and loss
- Childcare and eldercare resources
- Substance abuse

ALWAYS BY YOUR SIDE

- 24/7 support
- Convenient website
- Short-term help
- Monthly webinars
- Medical Bill Saver tool
- Referrals for additional care

Call **800-854-1446** or visit **www.unum.com/lifebalance** for support at any hour of the day or night.

NOTE

Get three in-person visits at no additional cost to you!

UNUM COVERAGES

ACCIDENT

Accident insurance from **Unum** provides affordable protection against a sudden, unforeseen accident. The Accident plans help offset the direct and indirect expenses resulting from an accident such as copayments, deductibles, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans.

Benefits are paid according to a fixed schedule for accident-related expenses, including hospitalizations, fractures, dislocations, emergency room visits, major diagnostic exams and physical therapy. The chart below shows only some of the benefits available. See the plan documents for details.

ACCIDENT INSURANCE		
SERVICE	BENEFIT	BENEFIT
	PLAN 1	PLAN 2
Ambulance ◆ Ground ◆ Air	 $300 $700	 $400 $1,000
Emergency Room	$300	$300
Hospital Admission	$1,000	$2,000
Hospital Confinement	$300 per day – up to 365 days	$400 per day – up to 365 days
Intensive Care Unit	$600 per day – added to hospital confinement	$800 per day – added to hospital confinement
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$50-$15,000	$65-$20,000
Accidental Death & Dismemberment* ◆ Teammate ◆ Spouse ◆ Child(ren)	 $50,000 $25,000 $12,500	 $75,000 $37,500 $18,750

*Percentage of benefit paid for dismemberment is dependent on type of loss.

MONTHLY RATES		
	PLAN 1	PLAN 2
Teammate Only	$11.40	$16.77
Teammate + Spouse	$19.72	$28.95
Teammate + Child(ren)	$30.03	$42.90
Teammate + Family	$38.35	$55.08

UNUM COVERAGES

HOSPITAL INDEMNITY

Hospital Indemnity insurance through **Unum** helps you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay. Unlike traditional insurance, which pays a benefit to the hospital or doctor, this plan pays you directly so you do not have to borrow money or pull from savings to pay for care. It is up to you how you want to use the cash benefit. These costs may include meals, travel, childcare or eldercare, deductibles, coinsurance, medication, or time away from work. The chart below shows only some of the benefits available. See the plan documents for full details.

HOSPITAL INDEMNITY INSURANCE		
SERVICE	BENEFIT	BENEFIT
	PLAN 1	PLAN 2
Hospital Admission	$1,000	$1,500
Hospital Confinement	$150 per day up to 31 days	$200 per day up to 31 days
ICU Confinement	$150 per day up to 15 days	$200 per day up to 15 days
MONTHLY RATES		
	PLAN 1	PLAN 2
Teammate Only	$15.90	$22.75
Teammate + Spouse	$33.97	$48.53
Teammate + Child(ren)	$26.52	$37.96
Teammate + Family	$44.59	$63.74

Food King

Cost Plus Food

COLONIAL LIFE COVERAGES

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an unexpected illness or accident, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel expenses, and non-medical expenses. This is where supplemental benefits can help provide extra financial protection. You have the opportunity to purchase the following benefits through **Colonial Life**.

WHOLE LIFE

You may choose between two whole life plan options that offer permanent coverage and premiums that do not increase. The policies offer a policy loan for emergencies, a stand-alone spouse policy, a $3,000 immediate claim payment to beneficiaries, an accelerated death benefit for terminal illness, and additional coverage options.

GROUP SHORT TERM DISABILITY

If a covered accident or covered sickness prevents you from earning a paycheck, group Short Term Disability (STD) insurance can provide a monthly benefit to help you cover your ongoing expenses – often at a more reasonable rate than individual insurance. You can tailor STD coverage to fit your specific needs, including monthly income and payment duration.

CRITICAL ILLNESS AND CANCER

The Critical Illness and Cancer insurance policy provides a benefit to help offset the out-of-pocket medical and indirect non-medical expenses related to cancer and/or critical illness. The policy provides a lump-sum benefit directly to you to use as you see fit. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. The chart below shows only some of the benefits available. See the plan document for full details.

CRITICAL ILLNESS INSURANCE	
FIRST OCCURRENCE BENEFIT	
Full Coverage Invasive cancer; heart attack; stroke; major organ failure requiring transplant; sudden cardiac arrest; loss of hearing, sight, or speech; benign brain tumor; coma	100% of benefit amount
Partial Coverage Non-invasive cancer; coronary artery disease	25% of benefit amount
Childhood Conditions Cerebral palsy; cleft lip or palate; cystic fibrosis; Down syndrome; spina bifida	100% of benefit amount
Wellness Benefit One per covered person per calendar year	$50
Pre-existing Condition Limitation	No benefit for a pre-existing condition that occurs during the 12-month period after coverage effective date.

POLICYHOLDERS PORTAL

If you become a Colonial Life policyholder, register for an account through the Colonial Life Policyholders Portal to easily and quickly file a claim and manage your benefits. The portal enables you to file claims, set up direct deposit for approved payments, view claims status, and more. Go to **www.coloniallife.com/access** to register and click *Create an Account*.

LEARN MORE

Call Colonial Life at **800-325-4368**.

LEGAL SUPPORT AND ID PROTECTION

If you need assistance with legal consultations, family matters, or small claims court, work with local plan attorneys through **LegalShield**.

LEGAL PROTECTION

Put a law firm in the palm of your hand with LegalShield. Benefits include:

- Family matters (e.g., adoption, eldercare, juvenile court, prenuptial agreements)
- Financial (e.g., affidavits, consumer protection, tax audit and collection service, bankruptcy)
- Home (e.g., boundary or title disputes, deeds, foreclosure, mortgages)
- Estate planning (e.g., probate, trusts, wills and codicils, living wills)
- Auto (e.g., driver's license restoration, moving traffic violations, motor vehicle property damage)
- General (e.g., 24/7 emergency access, document review, demand letters and phone calls on your behalf, consultations)

CONTACT INFORMATION

Download the **LegalShield app**

Call – **800-654-7757**

IDENTITY AND FRAUD PROTECTION

Metlife + Aura

Keep your identity and finances secure with **MetLife and Aura Identity and Fraud Protection**. As a member, you will benefit from credit monitoring, dark web monitoring, public records monitoring, and other protections.

To get the most out of your benefit, set up an account at **https://my.aura.com/start**. The more personal and financial information you provide for monitoring, the stronger your protection will be.

CONTACT METLIFE + AURA

Call **844-931-2872**

Access **https://my.aura.com/start**

Download the **Aura app**

TEAMMATE CONTRIBUTIONS

		Your 2026 Costs
MEDICAL*	**WEEKLY COST**	
Teammate Only	$35.00	**$**
Teammate + One or More	$100.00	
MDLIVE		
Teammate + One or More	Included with BCBSTX medical plan coverage	**$0**
DENTAL	**WEEKLY COST**	
Teammate Only	$4.83	**$**
Teammate + Spouse	$10.85	
Teammate + Children	$11.45	
Teammate + Family	$17.23	
VISION	**WEEKLY COST**	
Teammate Only	$1.28	**$**
Teammate + Spouse	$2.28	
Teammate + Children	$2.53	
Teammate + Family	$3.45	
LIFE AND AD&D		
Basic Life and AD&D	Paid by Pay and Save, Inc. for all teammates enrolled in the BCBSTX medical plan	**$0**
Voluntary Life and AD&D	See page 8 for rates	**$**
VOLUNTARY LONG TERM DISABILITY		
Teammate Only	See page 10 for rates	**$**
VOLUNTARY SUPPLEMENTAL BENEFITS		
Whole Life – Colonial Life	Schedule time to meet with a benefits specialist to review rates and options.	**$**
Group Short Term Disability – Colonial Life		**$**
Critical Illness and Cancer – Colonial Life		**$**
Accident – Unum		**$**
Hospital Indemnity – Unum		**$**
Identity and Fraud Protection – MetLife + Aura		**$**
Legal Services – LegalShield		**$**
YOUR TOTAL 2026 BENEFITS COST		**$**

***PAY AND SAVE, INC. CONTRIBUTES $611.36 FOR TEAMMATE ONLY COVERAGE OR $1,245.31 FOR TEAMMATE AND FAMILY COVERAGE.**

REQUIRED LEGAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT RIGHTS

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

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 enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Pay and Save, Inc.
Human Resources
1804 Hall Avenue
Littlefield, TX 79339
806-385-3366

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pay and Save, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pay and Save, Inc. has determined that the prescription drug coverage offered by the Pay and Save, Inc. medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Pay and Save, Inc. at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Pay and Save, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **806-385-3366**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

January 1 2026
Pay and Save, Inc.
Human Resources
1804 Hall Avenue
Littlefield, TX 79339
806-385-3366

NOTICE OF HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 23, 2013

Pay and Save, Inc.'s Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

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

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Pay and Save, Inc.
Human Resources
1804 Hall Avenue
Littlefield, TX 79339
806-385-3366

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

ALABAMA – MEDICAID

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA– MEDICAID

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) AND CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – MEDICAID

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

INDIANA – MEDICAID

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

REQUIRED LEGAL NOTICES

KANSAS – MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – MEDICAID

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – MEDICAID

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – MEDICAID

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – MEDICAID AND CHIP

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)

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – MEDICAID

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/chip/pages/chip.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – MEDICAID
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – MEDICAID
Website: https://dss.sd.gov Phone: 1-888-828-0059
TEXAS – MEDICAID
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
UTAH – MEDICAID AND CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– MEDICAID
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
VIRGINIA – MEDICAID AND CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – MEDICAID
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – MEDICAID AND CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since **July 31, 2025**, or for more information on special enrollment rights, can 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

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Company group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Company plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Pay and Save, Inc.
Human Resources
1804 Hall Avenue
Littlefield, TX 79339
806-385-3366

REQUIRED LEGAL NOTICES

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may 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 cannot balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

IMPORTANT CONTACTS

PROGRAM	CARRIER NAME	PHONE NUMBER	WEBSITE / EMAIL
Medical	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
Telemedicine/Virtual Visits	MDLIVE	888-680-8646	www.mdlive.com/bcbstx
Dental	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
Vision	VSP	800-877-7195	www.vsp.com
Life and AD&D	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
Whole Life	Colonial Life	800-325-4368	www.coloniallife.com
Short Term Disability	Colonial Life	800-325-4368	www.coloniallife.com
Critical Illness and Cancer	Colonial Life	800-325-4368	www.coloniallife.com
Accident	Unum	866-679-3054	www.unum.com
Hospital Indemnity	Unum	866-679-3054	www.unum.com
Long Term Disability	Unum	866-679-3054	www.unum.com
Employee Assistance Program	Unum/WorkLife Balance	800-854-1446	www.unum.com/lifebalance
Identity and Fraud Protection	MetLife/Aura	844-931-2872	https://my.aura.com/start
Legal Services	LegalShield	800-654-7757	www.legalshield.com
Benefits Administrator	Lowe's Market	806-385-3366, ext. 636	insurance@lowesmarket.com

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