OCEANS HEALTHCARE

EMPLOYEE BENEFITS GUIDE

2026

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Oceans Healthcare is proud to support our employees' overall wellbeing with a variety of benefit options. This guide offers details on our 2026 offerings for you and your family. Contact the Human Resources department with any questions.

See **page 40** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Oceans Acquisition, Inc. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

WELCOME

Oceans Healthcare appreciates the hard work and dedication you bring to our team every day. To do our part, we are committed to keeping your benefits affordable and beneficial for you and your eligible family members.

Oceans Healthcare strives to provide benefits that:

- Meet your needs
- Are easy to understand and use
- Provide excellent value for affordable costs

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

This guide is designed to assist you and your family in making the best choices for your needs in 2026. It contains explanations of each benefit, contact information for benefits vendors, and costs you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

Any questions?

Contact the Benefits Assistance Center at 833-981-0117 or email OceansHealthcarebenefits@bac.lockton.com.

Hours of Operation: M-F 7 a.m. – 6 p.m. CST

ELIGIBILITY AND ENROLLMENT

Oceans Healthcare's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Oceans Healthcare who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

Your elections are effective the first of the month following 30 days of employment. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

PRN and Part-Time employees meeting ACA full-time will be eligible to participate in Medical benefits.

Dependents

Dependents eligible for coverage include:

- Your legal spouse or domestic partner.
- Children under the age of 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

If you need assistance with what documents are needed to verify your dependents, please contact the Benefits Assistance Center at 833-981-0117 or email OceansHealthcarebenefits@bac.lockton.com.

Qualified Life Events

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 30 days to request, update, and finalize changes to your coverages. Your change in coverage must be consistent with your change in status.

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (Healthcare.gov)
- Changes in address or location that may affect coverage
- Turning 26 or losing coverage through a parent's plan
- A change in employment status from full-time to part-time, or part-tome to full-time, resulting in a gain or loss of eligibility
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Oceans Benefits Assistance Center with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

IMPORTANT CONTACTS

Medical
Blue Cross Blue Shield of Texas
800-521-2227
www.bcbstx.com
Policy #: 272727

Pharmacy
CVS Caremark
866-693-4621
www.caremark.com
Policy #: 21VG

Supplemental Health (Accident, Critical Illness)
AFLAC
800-462-3522
www.aflac.com

Virtual Medicine
Teladoc Health
800-835-2362
www.teladochealth.com/primary360

Wellness
Well on Target
877-806-9380
www.wellontarget.com

Tobacco Free Incentive
Navigate Wellbeing
888-282-0822
info@navigatewell.com

Dental
Cigna
800-244-6224; Pre-Enrollment:
800-564-7642
www.mycigna.com
Policy #: 3341770

Vision
MetLife
Superior
833-393-5433
www.metlife.com
Policy #: 0256217

Health Savings Account
Lively
888-576-4837
support@livelyme.com
livelyme.com

Health Reimbursement Account
Blue Cross Blue Shield of Texas
800-521-2227
www.bcbstx.com

Flexible Spending Accounts
Lively
888-576-4837
support@livelyme.com
livelyme.com

Life and AD&D
MetLife
800-638-6420
www.metlife.com
Policy #:0256217

Disability
MetLife
833-622-0135
www.metlife.com
Policy #: 0256217

Retirement
Principal
800-547-7754
www.principal.com

Employee Assistance Program
Compsych
833-256-5110
www.guidanceresources.com
Policy #: Ocean

Oceans Healthcare Human Resources
5360 Legacy Drive, Suite 101
Plano, TX 75024
benefits@oceanshealthcare.com
oceanshealthcarebenefits.com

MEDICAL BENEFITS

Medical benefits are provided through Blue Cross Blue Shield of Texas. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2026 plan year unless you have a Qualifying Life Event.

BlueCross BlueShield of Texas

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bi-weekly contributions.

	CORE HDHP	BUY-UP HDHP	EPO	HCA – PPO
BI-WEEKLY CONTRIBUTIONS				
EMPLOYEE ONLY	$32.26	$65.50	$81.26	$104.31
EMPLOYEE + SPOUSE	$143.98	$213.79	$238.90	$291.74
EMPLOYEE + CHILD(REN)	$117.31	$181.72	$201.42	$249.30
EMPLOYEE + FAMILY	$189.77	$297.01	$336.41	$415.87

The rates shown above exclude the 2026 tobacco user surcharge of $75/month, applicable to employees and/or spouses enrolled in medical coverage. This surcharge takes effect starting with the 4/10/26 pay date.

How to Find a Provider

Visit www.bcbstx.com or call Customer Care at 800-521-2227 for a list of Blue Cross Blue Shield of Texas network providers.

Visit BAM at bcbstx.com to log in or create an account. Then, choose **Find Care** to:

- Find in-network providers, clinic, hospitals, and pharmacies.
- Search by specialty, ZIP code, language spoken, gender, and more.
- View clinical certifications and recognitions.
- Compare quality awards for doctors, hospitals, and more.
- Read or share reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments, and tests*
- Manage your ID card and stay on top of claims activity, coverage information, and prescription refill reminders.

You can even search as a guest! Go to bcbstx.com, choose **Find Care** and use your **ZIP code** to find in-network providers near you.

Need more help?

Call 800-810-BLUE(2583) or text **BCBSAPP** to **33633**** to download the BCBSTX mobile app.

*Not all plans provide this information.
**Message and data rates may apply. Terms and conditions and privacy policy are available at bcbstx.com/mobile/text-messaging.

Medical Plan Summary

This chart summarizes the 2026 medical coverage provided by Blue Cross Blue Shield of Texas. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	OCEANS HEALTHCARE 2026 MEDICAL/RX PLAN DESIGN							
	CORE HDHP		BUY UP HDHP		EPO		HCA-PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HCA EMPLOYER PLAN FUNDING**	No		No		No		**Individual: $500 Family: $1,000**	
CALENDAR YEAR DEDUCTIBLE								
INDIVIDUAL	**$8,500**	**$17,000**	**$4,500**	**$9,000**	**$6,000**	Not covered	**$6,000**	**$13,500**
FAMILY	**$17,000**	**$34,000**	**$9,000**	**$18,000**	**$12,000**	Not covered	**$12,000**	**$27,000**
RX DEDUCTIBLE	Combined with Medical		Combined with Medical		$200 per person		None	
COINSURANCE (MEMBER PAYS)	0%*	0%*	20%*	50%*	20%*	50%*	20%*	50%*
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)								
INDIVIDUAL	**$8,500**	**$17,000**	**$6,500**	**$13,000**	**$8,500**	Not covered	**$8,500**	**$17,000**
FAMILY	**$17,000**	**$34,000**	**$13,000**	**$26,000**	**$17,000**	Not covered	**$17,000**	**$34,000**
COPAYS/COINSURANCE								
PREVENTIVE CARE	0%	0%*	0%	50%*	0%	Not covered	0%	50%*
PRIMARY CARE	0%*	0%*	20%*	50%*	$35 copay	Not covered	20%*	50%*
SPECIALIST SERVICES	0%*	0%*	20%*	50%*	$70 copay	Not covered	20%*	50%*
TELADOC	0%	Not covered	0%	Not covered	$0	Not covered	0%	Not covered
SIMPLE LAB/X-RAY	0%*	0%*	20%*	50%*	No charge (after copay)	Not covered	20%*	50%*
MENTAL HEALTH – INPATIENT	0%*	0%*	0%	0%	0%	Not covered	0%	0%
MENTAL HEALTH – OUTPATIENT	0%*	0%*	0%	0%	0%	Not covered	0%	0%
URGENT CARE	0%*	0%*	20%*	50%*	$75 copay	Not covered	20%*	50%*
EMERGENCY ROOM	0%*	0%*	20%*	50%*	$1,000 copay, then 20%	Not covered	20%*	20%*
RETAIL RX (UP TO 30-DAY SUPPLY)								
GENERIC	0%*	0%*	$10*	$10*	$20*	$20*	$10	$10
PREFERRED BRAND	0%*	0%*	$40*	$40*	$80*	$80*	$40	$40
NON-PREFERRED BRAND	0%*	0%*	$60*	$60*	$120*	$120*	$60	$60
SPECIALTY	0%*	0%*	30%*	Not covered	30%	Not covered	30%	Not covered
MAIL ORDER RX (UP TO 90-DAY SUPPLY)								
GENERIC	0%*	0%*	$20*	$20*	$40*	$40*	$20	$20
PREFERRED BRAND	0%*	0%*	$80*	$80*	$160*	$160*	$80	$80
NON-PREFERRED BRAND	0%*	0%*	$120*	$120*	$240*	$240*	$120	$120

*Employee cost-share after deductible
**Annual Funding Amount (prorated for new hires)

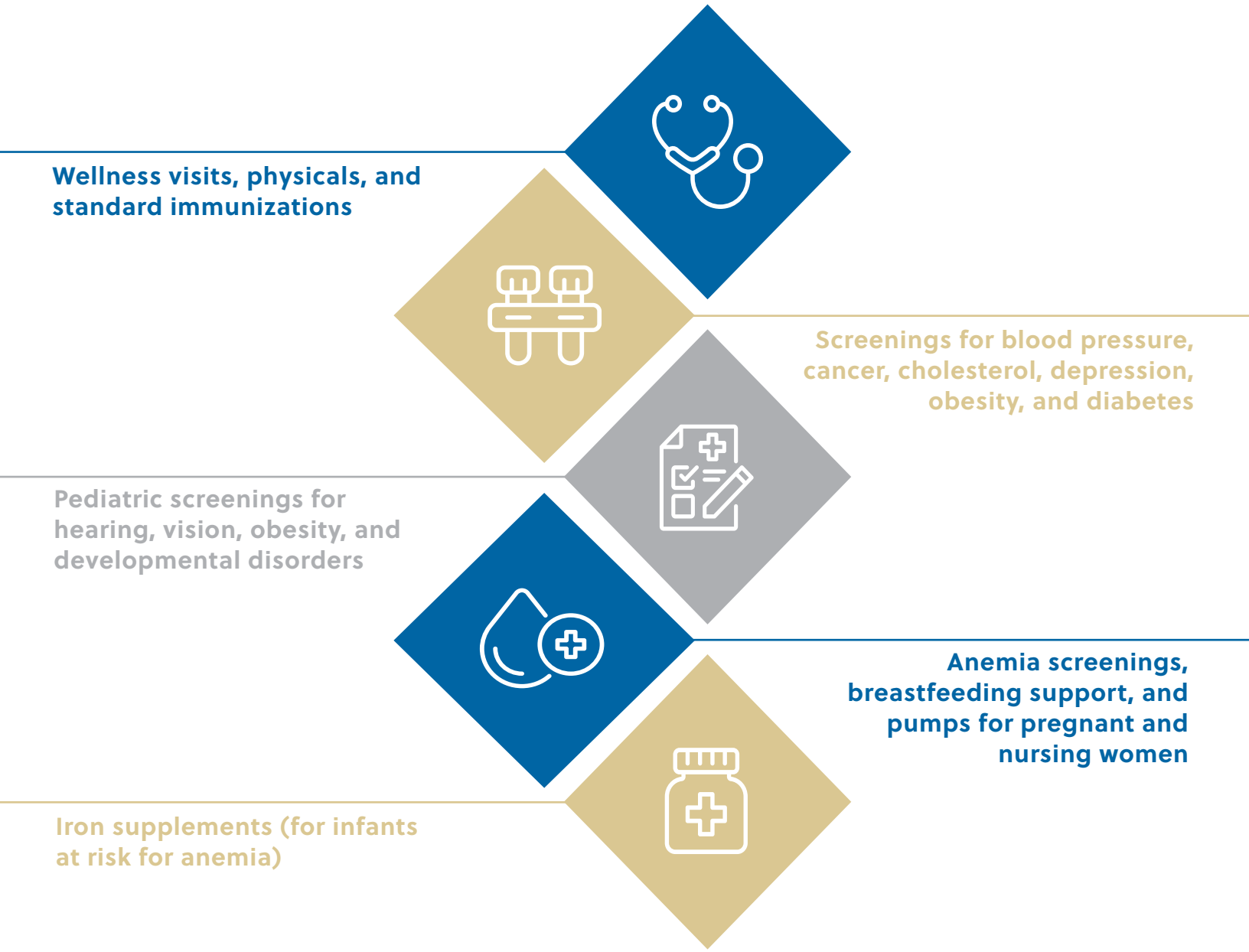
While the Core HDHP plan has higher deductible and out-of-pocket limits — this option provides 100% coverage for all covered Medical and pharmacy services after the deductible has been met.

The Buy-Up HDHP plan has lower deductible limits — but employees pay 20% of all ongoing covered expenses until the out-of-pocket maximum is reached.

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same applies for the out-of-pocket maximum.

PREVENTIVE CARE

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:



Wellness visits, physicals, and standard immunizations

Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Iron supplements (for infants at risk for anemia)

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults.

OUT-OF-POCKET COSTS

These are the types of payments you're responsible for:

COPAY

The fixed amount you pay for healthcare services at the time you receive them.

DEDUCTIBLE

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

OUT-OF-POCKET MAXIMUM

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

COINSURANCE

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

HOW TO PICK A PLAN

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- If you or your dependent(s) expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How does a HDHP (High Deductible Health Plan) work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

How does an EPO (Exclusive Provider Organization) plan work?

An EPO is an exclusive provider organization that does not cover out-of-network care except in the case of a true emergency.

TOBACCO-FREE INCENTIVE

Starting in 2026, employees and spouses/domestic partners enrolled in a 2026 medical plan can avoid a biweekly tobacco surcharge by completing the annual tobacco-free incentive program by March 15, 2026.

To complete the program, participants must **complete one** of the following **company-paid** options by **March 15, 2026**:

- Register and complete a **"negative" Cotinine test*** through our lab partner**, or
- Register and complete **three virtual tobacco coaching sessions** through Navigate Wellbeing

Beginning on **April 10, 2026**, a **biweekly tobacco surcharge** will be applied to any employee and/or covered spouse/domestic partner who did **not** complete the tobacco-free incentive requirement by March 15, 2026. *Employees may complete testing/coaching after March 15th to remove the tobacco surcharge on the pay period following the monthly notification from Navigate.*

Biweekly Surcharge Amounts:

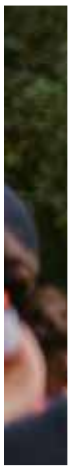
- **Employee only:** $34.62 biweekly ($75/month)
- **Spouse/Domestic Partner only:** $34.62 biweekly ($75/month)
- **Employee & Spouse/Domestic Partner:** $69.24 biweekly ($150/month)

Key Dates and Details:

- Program opens **December 1, 2025**
  - Initial program completion window: **December 1, 2025 – March 15, 2026**
- Navigate Wellbeing will manage the program through wellbeing app/portal
  - Access instructions for the app/portal and lab registration will be provided on 12/1/25 to employees and spouses/domestic partners enrolled in a 2026 medical plan

*A cotinine test is a blood draw or a saliva swab test that detects active tobacco or nicotine use (cigarettes, cigars, vaping, etc.) or exposure to nicotine-containing products (e.g., patches, gum, e-cigarettes).
**Onsite screenings will be completed via an oral swab. Screenings at offsite labs will be completed via a blood draw.

Navigate Wellbeing Solutions



NOTE

According to the CDC, quitting smoking improves your health and quality of life and can even add up to 10 years to your life expectancy!

VIRTUAL MEDICINE

When you're under the weather, there's no place like home, and if you're busy with work and family, scheduling an in-person doctor's appointment can be a pain. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

Teladoc HEALTH

Oceans Healthcare provides a virtual medicine benefit through Teladoc Health for you and your dependents. Teladoc Health offers on-demand access to board-certified doctors through online video, telephone, or secure email. This program is available at **$0 copays and 0% deductibles for all plans.**

Please note that some states do not allow physicians to prescribe medications via virtual medicine. For more information, visit www.Teladoc.com.

Teladoc Health doctors can treat many medical conditions, including:

- Cold and flu
- Allergies
- Bronchitis
- Bladder infection/ urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

Access Virtual Visits

Connect with healthcare professionals and start feeling your best with Primary360 by Teladoc Health. Schedule doctor appointment within minutes and see a doctor in as soon as 5 days.

- Care options include:
- Primary care
- General medicine
- Dermatology
- Mental health

To activate your Teladoc Health Primary360 benefit, either download the Teladoc Health app, call 800-835-2362, or visit TeladocHealth.com/Primary360.

NOTE

A virtual visit directly with your primary care physician (vs. Teladoc Health) might also be an option — and typically costs the same as an office visit.

WHERE TO GO FOR CARE

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

NURSE LINE

WHEN TO USE

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Call 800-581-0368 to speak directly with a licensed nurse.

TYPES OF CARE*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

COSTS AND TIME CONSIDERATIONS**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

VIRTUAL MEDICINE ($)

WHEN TO USE

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

TYPES OF CARE*

- Cold and flu symptoms
- Bronchitis
- Urinary tract infection
- Sinus problems

COSTS AND TIME CONSIDERATIONS**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Typically immediate access to care
- Prescriptions through virtual medicine or virtual visits not allowed in all states

PRIMARY CARE CENTER ($)

WHEN TO USE

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

TYPES OF CARE*

- Routine checkups
- Immunizations
- Preventive services
- Managing your general health

COSTS AND TIME CONSIDERATIONS**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

URGENT CARE CENTER ($$)

WHEN TO USE

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

TYPES OF CARE*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns

COSTS AND TIME CONSIDERATIONS**

- Copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but urgency determines order seen and wait time

EMERGENCY ROOM ($$$)

WHEN TO USE

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

TYPES OF CARE*

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

COSTS AND TIME CONSIDERATIONS**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

DO YOUR HOMEWORK

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

BCBSTX CLINICAL PROGRAMS

Diabetes Management: Teladoc Health

Diabetes Management and Hypertension Management Solutions

- Welcome kit with smart glucose meter or connected blood pressure cuff.
- Digital and live coaching through meter, phone and the Teladoc Health mobile app.

Digital Musculoskeletal (MSK) Clinic: Hinge Health

- Hinge Health provides a complete solution – for each stage of your MSK journey, with expert medical opinion.
- Hinge health will provide Prevention job-specific exercises and education, acute physical therapy video visits for every body part, chronic exercise, and behavioral change, and surgery rehab.
- Hinge Health will contact you about signing up for the program that is right for you.

Diabetes Prevention and Hypertension Management: Omada

- Services covered — no out of pocket cost.
- Employees will receive a welcome kit connected weight scale or connected blood pressure cuff (4 sizes)
- Personal health coach for one-on-one guidance.
- If eligible, Omada will contact you about how to sign up for these programs.

Metabolic Syndrome Reversal Program: Wondr Health

- Online program and mobile app allows members to access anywhere at anytime
- Wondr is a skills-based digital weight loss program that teaches you how to enjoy the foods you love and improve your overall health at no cost to you.

Member Discount Program: Blue 365

- Exclusive health and wellness deals from national and local retailers
- Save money on fitness gear, family activities, gym memberships, healthy eating, dental, vision, hearing aids and more from top national and local retailers
- Go to www.blue365deals.com/bcbstx to register, view your available discounts and sign up for weekly emails.

If Eligible for one or more of these programs, BCBSTX will reach out on your behalf. However, employees are welcome to contact BCBSTX directly for more information regarding these additional program offerings. Additional information is available on your Blue Access for Members (BAM) portal at www.bcbstx.com.

NOTE

Keep healthcare costs down by seeing the right provider for your situation. See page 12 for more information.

Diabetes Management, Simplified

Teladoc Health

Oceans Healthcare offers Teladoc Diabetes Management Care to you. Once you register for Teladoc Health, you will receive your welcome kit in 3-5 days.

The program is provided to you and your family members with diabetes and coverage through Blue Cross and Blue Shield of Texas (BCBSTX).

You will get this and more when you sign up:

- Unlimited testing strips
- Connected blood glucose meter
- Personalized insights
- Expert Coaching

Get Started Today at No Cost to You

Online: www.teladochealth.com/bright/HEALTH-TX
Phone: 800-835-2362

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit **www.bcbstx.com** to learn more.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

The Oceans Healthcare Prescription Drug Program is coordinated through CVS Caremark. This means you will have two ID cards: one for medical care and one for prescriptions. You may find information on our benefits coverage and search for network pharmacies by logging on to www.caremark.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

Prudent Rx Program

Prudent Rx is a specialty drug copay program to help members pay for certain eligible specialty and chronic condition medications. Enrolled members will be subject to a percentage-based coinsurance (30%) that may be offset partially or entirely by the copay program, greatly reducing the out-of-pocket cost of the medication. Program administrator will contact you if you qualify to participate.

	CORE HDHP		BUY-UP HDHP		EPO		HCA – PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RX DEDUCTIBLE	Combined with Medical		Combined with Medical		$200 per person		None	
RETAIL RX (30-DAY SUPPLY)								
GENERIC	0%*	0%*	$10*	$10*	$20*	$20*	$10	$10
PREFERRED	0%*	0%*	$40*	$40*	$80*	$80*	$40	$40
NON-PREFERRED	0%*	0%*	$60*	$60*	$120*	$120*	$60	$60
SPECIALTY DRUGS	0%*	0%*	30%*	Not covered	30% coinsurance	Not covered	30% coinsurance	Not covered
MAIL ORDER RX (90-DAY SUPPLY)								
GENERIC	0%*	0%*	$20*	$20*	$40*	$40*	$20	$20
PREFERRED	0%*	0%*	$80*	$80*	$160*	$160*	$80	$80
NON-PREFERRED	0%*	0%*	$120*	$120*	$240*	$240*	$120	$120

*Employee cost-share after deductible

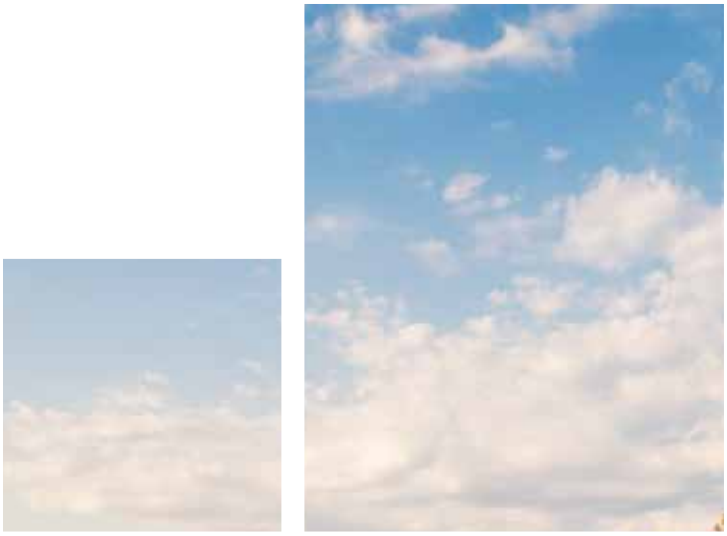
Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Lowering Medication Costs

How do prescription discount programs work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription may not count toward your deductible or out-of-pocket maximum under the benefit plan.

- **GoodRx** is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80% on generics.
- **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the
- **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by Inside Rx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.



MENTAL HEALTH

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and up to six face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Oceans Healthcare. You may access information, benefits, educational materials, and more by phone at **833-256-5110 or online at www.guidanceresources.com with code "Ocean" as the company ID.**

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Mental Health and Your Medical Plan

When your covered EAP services run out, the medical plan will cover behavioral and mental health services. Mental health coverage via the BCBSTX medical plans includes access to local therapists and virtual therapy from Teladoc Health via video or telephone.

- EPO & HCA medical plans cover inpatient & outpatient at 100% (no deductibles)
- HDHPs cover at 100% after the deductible

To find a provider go to www.bcbstx.com.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

PRACTICE MINDFULNESS.

Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.

STRENGTHEN SOCIAL CONNECTIONS.

Reach out to a friend or family member daily — even if it's just a call or text.

GET QUALITY SLEEP.

Keep a consistent sleep schedule and limit electronic use before bed.

IMPROVE YOUR OUTLOOK.

Treat people with kindness, including yourself.

DEAL WITH YOUR STRESS IN HEALTHY WAYS.

Think positively, exercise regularly, and set priorities.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HOME" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families can call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

NOTE

According to the Centers for Disease Control, nearly 22% of adults received help for mental health in 2021.

HEALTH SAVINGS ACCOUNT

For High Deductible Health Plan Participants

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Lively will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Lively

NOTE

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

PRE-TAX PAYCHECK CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS (PRE-TAX)

HSA

TAX-FREE PAYMENTS
(FOR QUALIFIED MEDICAL EXPENSES)

UNUSED FUNDS ROLL OVER ANNUALLY

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in Oceans Healthcare's HSA, you must elect the HDHP Plan with Blue Cross Blue Shield of Texas. Choose the amount to contribute on a pre-tax basis. Lively will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with Lively. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2026, contributions (which include any employer contribution) are limited to the following:

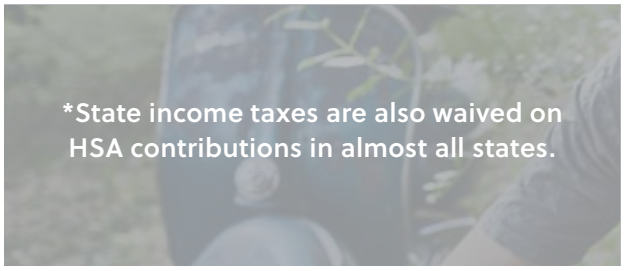
2026 CALENDAR YEAR HSA FUNDING LIMITS	
EMPLOYEE	$4,400
FAMILY	$8,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits ($4,400 for individual coverage and $8,750 for family coverage for 2026) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Oceans Healthcare HSA is established with Lively. You may be able to roll over funds from another HSA. For more enrollment information visit www.livelyme.com.



FLEXIBLE SPENDING ACCOUNTS

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Lively

Healthcare Flexible Spending Account

For EPO and HCA Participants

You can contribute up to $3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Limited Purpose Flexible Spending Account

For HDHP Participants Only

A Limited Purpose Flexible Spending Account (LPFSA) works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. The contribution limit is $3,400.

Dependent Care Flexible Spending Account

For All Employees

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact Lively with reimbursement questions. If you need to submit a receipt, Lively will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2026 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

NOTE

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

FSA vs HSA

FLEXIBLE SPENDING ACCOUNTS		HEALTH SAVINGS ACCOUNT
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You must be enrolled in a qualified Medical plan with Oceans to elect a Healthcare FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
You can contribute up to $3,400 in 2026 to an FSA. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,400 in 2026 (up to $8,750 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

HEALTH CARE ACCOUNT

For HCA Plan Participants

When you elect the HCA-PPO Plan, Oceans Healthcare will automatically establish a Health Care Account (HCA) in your name and contribute to that account.

An HCA is a pot of money that's IRS approved and employer funded. You can use the funds to cover costs that you would normally pay out of pocket for before meeting your deductible.

HCA FUNDING	
EMPLOYEE	$500
FAMILY	$1,000

You can use your HCA dollars for yourself and any dependents on your plan, such as your spouse and/or child(ren). When you have a qualified medical expense, inform your provider that you have the HCA plan to have the claim submitted and paid by your plan directly. Eligible Medical Expenses

- Any qualified medical expenses covered by the plan. Think doctors' visits, diagnostic tests, PPE, and prescriptions.
- Any combination of deductible, coinsurance, or copay expenses.

Using Your HCA

You can use your HCA dollars toward your deductible. If you run out of HCA funds before meeting your deductible, you'll pay out of pocket until the deductible amount is reached. Preventive care is covered 100% by the plan, so there's no need to use HCA dollars.

Submitting a Claim

When you receive a covered service from an in-network provider, the provider submits the claim to the plan for processing to ensure that:

- The service is covered.
- You receive any discounts that have been negotiated with a network physician.
- The claim counts toward the deductible and out-of-pocket maximum.

Blue Cross Blue Shield of Texas will then use available HCA funds to pay the provider directly for expenses applied to the deductible.

IRS Rules

- Only the employer can contribute to an HCA.
- If your HCA dollars are not completely used in a plan year, the unused funds will be forfeited.
- Any contributions the employer makes to the HCA are not taxable to you. Further, any qualified claim payments made from your HCA are not taxable to you.

BlueCross BlueShield of Texas

NOTE

The HCA is owned by Oceans Healthcare, so if you leave, the funds stay behind and you will no longer have access to them, unless you elect COBRA.

DENTAL BENEFITS

Like brushing and flossing, visiting your dentist is an essential part of your Oceans Healthcare offers affordable plan options from Cigna for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at www.mycigna.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bi-weekly premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Cigna for 2026.

	DENTAL CORE		DENTAL BUY-UP	
BI-WEEKLY CONTRIBUTIONS				
EMPLOYEE ONLY	$10.36		$17.41	
EMPLOYEE + ONE DEPENDENT	$17.99		$33.96	
EMPLOYEE + FAMILY	$33.24		$50.04	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$75	$75	$50	$50
FAMILY	$225	$225	$150	$150
CALENDAR YEAR MAXIMUM				
PER PERSON	$750	$750	$1,500	$1,500
COVERED SERVICES				
PREVENTIVE SERVICES	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
BASIC SERVICES	20%*	20%*	20%*	20%*
MAJOR SERVICES	50%*	50%*	50%*	50%*
ORTHODONTICS Employees and Dependents	Not covered		50%	
ORTHODONTIC LIFETIME MAXIMUM	Not covered		$1,000 per member	

*Employee cost-share after deductible

VISION BENEFITS

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through MetLife.

MetLife

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bi-weekly premium.

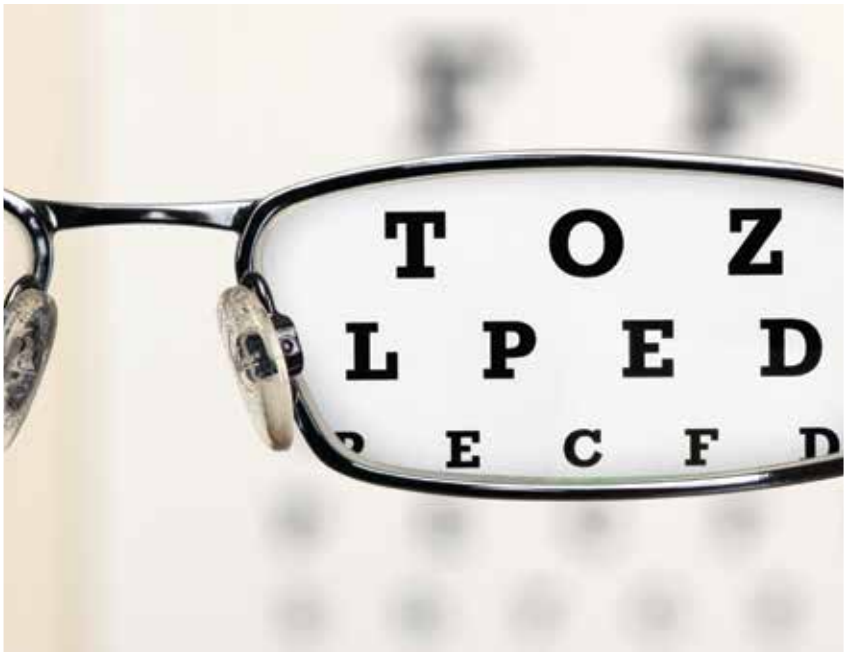
Vision Plan Summary

This chart summarizes the vision coverage provided by MetLife for 2026.

SUPERIOR VISION PLAN

BI-WEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$2.52		
EMPLOYEE + ONE DEPENDENT	$4.85		
EMPLOYEE + FAMILY	$8.25		
	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
EXAMS			
COPAY	$10 copay	Up to $42	12 months
LENSES			
SINGLE VISION	$0*	Up to $26	12 months
BIFOCAL	$0*	Up to $34	
TRIFOCAL	$0*	Up to $50	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
ELECTIVE	$150 allowance	Up to $100	12 months
MEDICALLY NECESSARY	Covered in full	Up to $210	
FRAMES			
ALLOWANCE	$150 allowance	Up to $52	12 months

*Employee cost-share after copay



LIFE AND AD&D INSURANCE

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Company Paid Life and Accidental Death & Dismemberment Insurance

Oceans Healthcare provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through MetLife, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

EMPLOYEE CLASS	BASIC LIFE/AD&D BENEFIT
Full-Time Employees	1x earnings, up to $50,000
Part-time and PRN Employees	$15,000 benefit

Naming a Beneficiary

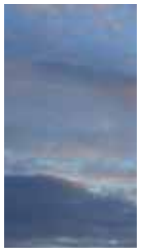
Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the MetLife insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$500,000 or 5x basic annual earnings (lesser of)
EVIDENCE OF INSURABILITY (EOI) REQUIRED	$100,000 or 3x annual earnings (lesser of)
VOLUNTARY SPOUSE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$250,000 or 50% of employee election (lesser of)
EVIDENCE OF INSURABILITY (EOI) REQUIRED	$50,000
VOLUNTARY CHILD LIFE/AD&D	
COVERAGE AMOUNT	Age 14 days – 6 months: $250; 6 months – age 26: $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A



VOLUNTARY LIFE/AD&D INSURANCE

RATES/$1,000 (BI-WEEKLY)			
AGE (AS OF JANUARY 1, 2026)	EMPLOYEE	AGE (AS OF JANUARY 1, 2026)	SPOUSE
<25	$0.048	<25	$0.048
25-29	$0.048	25-29	$0.048
30-34	$0.053	30-34	$0.053
35-39	$0.076	35-39	$0.076
40-44	$0.104	40-44	$0.104
45-49	$0.168	45-49	$0.168
50-54	$0.252	50-54	$0.252
55-59	$0.445	55-59	$0.445
60-64	$0.669	60-64	$0.669
65-69*	$1.032	65-69*	$1.032
70-74*	$1.798	70-74*	$1.798
75+*	$3.115	75+*	$3.115
AD&D	$0.0055	AD&D	$0.0115

*Benefits subject to age reduction schedule

VOLUNTARY CHILD LIFE INSURANCE

RATES/$1,000 (BI-WEEKLY)	
Child Life	$0.1154
Child AD&D	$0.0115

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Bi-Weekly Premium

DISABILITY BENEFITS

You and your loved ones depend on your regular income. That's why Oceans Healthcare offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Employee-Paid Short-Term Disability (STD) Insurance

STD benefits are available for purchase on a voluntary basis. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or the Benefits Assistance Center for details.

WEEKLY MAXIMUM BENEFIT	$1,000
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	11 weeks

Employee-Paid Long-Term Disability (LTD) Insurance

LTD benefits are available for purchase on a voluntary basis. This insurance replaces 50% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or the Benefits Assistance Center for details.

MONTHLY MAXIMUM BENEFIT	$5,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Own Occupation: 24 months Any Occupation: SSNRA

MetLife

VOLUNTARY STD/LTD		
AGE (AS OF JANUARY 1, 2026)		
AGE RANGE	STD (RATE/$10 OF WEEKLY BENEFIT)	LTD (RATE/$100 OF MONTHLY SALARY)
<30	$0.191	$0.0471
30-34		$0.0974
35-39		$0.1588
40-44		$0.2566
45-49		$0.3646
50-54		$0.5252
55-59		$0.6572
60-64		$0.5354
65-69		$0.3097
70+		$0.2275

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60%	$	x Rate	$	÷ $10	$	
Annual Salary		Weekly Income		Weekly Benefit		Amount		Bi-Weekly Premium	

TO CALCULATE HOW MUCH YOUR LTD COVERAGE WILL COST:

$	÷ 12 =	$			x Rate	$	÷ $100	$	
Annual Salary		Monthly Covered Payroll				Amount		Bi-Weekly Premium	

VOLUNTARY BENEFITS

MetLife Identity and Fraud

Identity theft protection is available on a voluntary basis. There is a new identity fraud victim every two seconds. Protect yourself with MetLife Aura. MetLife Aura monitors millions of transactions every second, alerting you to suspicious activity by text, phone, or email. This plan offers a full set of features to help protect you and your covered family members against identity theft.

MetLife Aura membership features:

- MetLife Aura Identity Alert System
- Lost-wallet protection
- Address change verification
- MetLife Aura Privacy Monitor
- Live member service support
- Identity-restoration support
- Data-breach notifications

This plan is available via payroll deduction and is yours to keep if you retire or leave Oceans. Enroll for Identity Theft Protection in PayCom during annual enrollment.

Website: www.metlife.com/identity-and-fraudprotection

IDENTIFY & FRAUD PROTECTION BI-WEEKLY RATES FOR COVERAGE	
	PROTECTION PLUS PLAN
EMPLOYEE ONLY	$3.90
EMPLOYEE + FAMILY	$6.44

MetLife Legal Plan

MetLife offers low-cost access to attorneys for personal legal services. Payments are made conveniently through payroll deductions. It's like having your own attorney on retainer for a lot less. There are attorneys standing by to assist you with:

- Estate planning, wills, and trusts
- Real-estate matters
- Identity-theft defense
- Financial matters, such as debt-collection defense
- Traffic offenses
- Document review
- Family law, including adoption and name change
- Advice and consultation on personal legal matters
- Divorce

Enroll for Prepaid Legal Coverages in PayCom during annual enrollment.

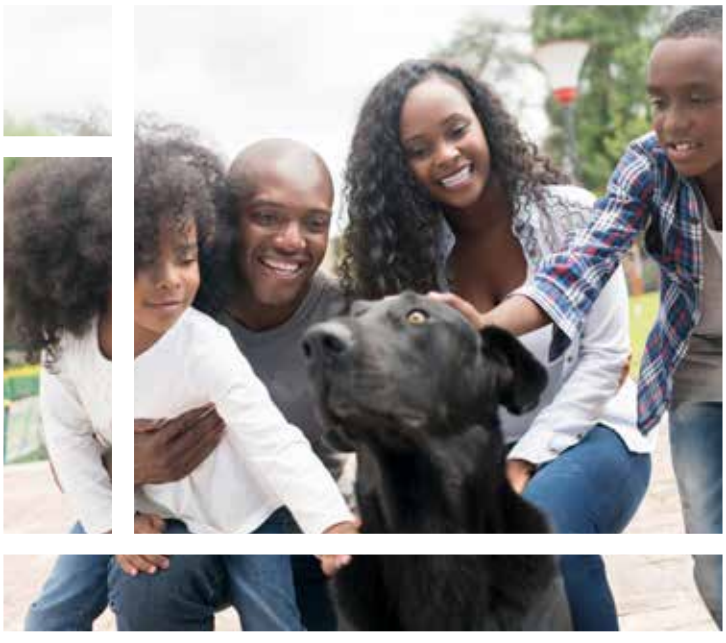
MetLife Pet Insurance

We know your pets are part of the family, and just like any other family member, our furry friends are bound to have some medical expenses from time to time. For the most part, these expenses come from standard checkups and immunizations, but the occasional unexpected illness or injury can rack up some significant bills when you least expect it. Pet insurance through MetLife Pet Insurance provides coverage for veterinary expenses related to accidents and illnesses, including X-rays, medications, vet visits, surgeries, and hospital stays. Policies are available for dogs, cats, birds, reptiles, and exotic pets. Optional wellness coverage is also available for dogs and cats, providing reimbursement for preventive care. To enroll or for additional information, please call 800-GET-MET8 or visit www.metlife.com on or after January 1, 2026, to get started.

MetLife Auto and Home Insurance

You have access to discounted auto and homeowners insurance through Farmers. Your coverage stays with you even if you switch jobs. Homeowners insurance includes coverage for your house, condo, or rental property. Residency restrictions may apply. Auto insurance includes coverage for your vehicle, boat, motor home, or recreational vehicle. You may start or stop your coverage at any time during the year. Call 800-438-6381 on or after January 1, 2026 to sign up.

MetLife



VOLUNTARY BENEFITS (CONT.)

Oceans Healthcare offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Aflac Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any unexpected expenses. Accident coverage through AFLAC provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits are payable to you directly.

ACCIDENT PLAN (24 HOUR COVERAGE)

BENEFITS	BENEFIT AMOUNT
WELLNESS	$90/year; 1 per policy
INITIAL HOSPITAL ADMISSION	$1,000
INITIAL ICU HOSPITAL ADMISSION	$2,000
HOSPITAL CONFINEMENT	$250 day; up to 365 days
ICU CONFINEMENT	$400 day; up to 15 days
INITIAL ER / DR VISIT	$200
GROUND AMBULANCE	$200
AIR AMBULANCE	$1,500
FOLLOW-UPS	$35 each; up to 6 visits
THERAPY	$35 each; up to 10 visits
APPLIANCE	$$25 – $300
DISLOCATIONS	$100 – $3750
BURNS	$125 – 12,500
FRACTURES	$125 – $3500
COMA	$12,500
SURGICAL PROCEDURES	$200 – $1,250
ACCIDENTAL DEATH BENEFIT ADULT / KIDS	$50,000 per adult / $12,500 per child

ACCIDENT PLAN

COVERAGE	BI-WEEKLY DEDUCTIONS
EMPLOYEE ONLY	$12.42
EMPLOYEE + SPOUSE	$16.56
EMPLOYEE + CHILDREN	$19.26
EMPLOYEE + FAMILY	$24.24

Aflac Critical Illness Coverage

Critical Illness coverage through AFLAC pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Employee: $15,000 or $30,000
  - Coverage is available for Spouse/Domestic Partner and Children.
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion; however, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.
- Wellness Benefit: A $50-$100 wellness benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy, or stress test.

CRITICAL CARE PLAN – BENEFITS

BENEFIT NAME	BENEFIT AMOUNT
FIRST OCCURRENCE BENEFIT	$10,000/$12,500 lifetime
SUBSEQUENT SPECIFIED HEALTH EVENT	$5,000; no lifetime
CORONARY ANGIOPLASTY BENEFIT	$1,000/person; lifetime
HOSPITAL CONFINEMENT BENEFIT	$300/day; no lifetime
AMBULANCE BENEFIT	$250 ground/$2,000 air
CONTINUED CARE BENEFIT	$125/day; 75 days
TRANSPORTATION BENEFIT	$0.50/mile
LODGING BENEFIT	$75/day

(SEE BROCHURE / POLICY FOR MORE DETAILS)
TEXAS HAS 30 ELIMINATION ON ALL SICKNESS PLANS

CRITICAL CARE PLAN BI-WEEKLY DEDUCTIONS

AGE	INDIVIDUAL	1-PARENT	INSURED/SPOUSE	FAMILY
18-35	$4.32	$4.80	$6.18	$7.14
36-45	$6.72	$6.96	$10.32	$11.40
46-55	$9.36	$9.66	$15.48	$16.80
56-70	$12.60	$12.90	$22.68	$16.80

Enroll in the AFLAC Voluntary Benefits by phone at 337-519-1142 or by emailing angela_vergenal@us.aflac.com

Aflac Cancer Plan Rates and Benefits

CANCER CARE PLAN (BBR RIDER $500/CHILD RIDER)	
BENEFITS	**BENEFIT AMOUNT**
CANCER SCREENING	$75/year; 1 per person covered
INITIAL DIAGNOSIS	Insured/Spouse $5,000; Child $18,000
HOSPITALIZATION FOR 30 DAYS OR LESS	Insured/Spouse $200/day; Child $250/day
HOSPITALIZATION FOR MORE THAN 30 DAYS	Insured/Spouse $400/day; Child $500/day
RADIATION / CHEMO / IMMUNOTHERAPY / EXPERIMENTAL CHEMO	$250 self administered/ $1,200 physician administered
SURGERY / ANESTHESIA	$100 – $3,400
SKIN CANCER SURGERY	$35 – $400
BREAST RECONSTRUCTION	$100 – $2.000
ANTINAUSEA	$100/yearly
STEM CELL TRANSPLANTATION	$7,000; lifetime max
BONE MARROW TRANSPLANTATION	$7,000; lifetime max
GROUND AMBULANCE	$250
AIR AMBULANCE	$2,000.00
TRANSPORTATION	$0.40/mile; up to $1,200 year
LODGING	$65/night; up to 90 days
COMA	$12,500
HOSPICE CARE	$1,000 day 1 / $50 daily after / $12,000 lifetime
POLICY GROWS EACH YEAR / CANCER FREE	$500 per year

TEXAS HAS 30 DAY ELIMINATION ON ALL SICKNESS PLANS

CANCER CARE PLAN (BBR RIDER $500/CHILD RIDER)	
COVERAGE	**BI-WEEKLY DEDUCTIONS**
EMPLOYEE ONLY	$18.21
EMPLOYEE + SPOUSE	$33.09
EMPLOYEE + CHILDREN	$18.63
EMPLOYEE + FAMILY	$33.51

Enroll in the AFLAC Voluntary Benefits by phone at 337-519-1142 or by emailing angela_vergenal@us.aflac.com.

401(k) PLAN

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Principal

Contributing to a 401(k) account now can help keep you financially secure later in life. The Oceans Healthcare 401(k) plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	Oceans Healthcare 401(k) Plan
RECORDKEEPER	Principal
WEBSITE	www.principal.com
PHONE	800-547-7754
ELIGIBILITY	First of the month following three months of service
ENROLLMENT	▪ You are automatically enrolled after 90 days employment at a contribution rate of 3% ▪ Default contribution rates automatically increase by 1% per year until a rate of 10% is achieved ▪ Employees can alter their elections at any time online or by contacting Principal

All About 401(k)

This employer-sponsored retirement account can help your future self by saving money — tax-free — from your paycheck. The sooner you participate in a 401(k), the more time your assets have to grow.

Eligible employees can invest for retirement while receiving tax advantages. Administrative services are provided by Principal. You may start making pre-tax contributions into the plan first of the month following three months of service. You must be at least 18 years of age to be eligible.

Pre-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions are taken out before taxes each pay period, which will lower your annual taxable income. Pre-tax contributions grow on a tax-deferred basis and you won't pay taxes on these dollars until a distribution is taken at retirement. If you choose the available Roth 401(k), contributions are deducted from your paycheck after taxes — so although you are paying taxes on those dollars now, you won't pay taxes when you withdraw during retirement.

Contributing to the Plan

As a participant in the 401(k) Plan, you are able to save for retirement to help you achieve your retirement goals. The IRS limits the amount you can save annually, but if you are over age 50, you can contribute even more to the plan through catch-up contributions. Starting in 2025, there is even a special catch-up period for people turning 60 to 63.

The annual IRS limit for 2026 is $24,500, and the standard catch-up contribution limit for individuals ages 50 and older is $8,000. Starting January 1, 2025, the years you turn ages 60, 61, 62, and 63 you can save an additional amount up to $11,250. **Note: The standard catch-up limit resumes the year you turn age 64.**

Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in and you won't be subject to penalties for overcontributing.

How Much Should I Save?

Industry standards suggest saving at least 12% to 15% of your income. If you can't afford to save that much, make sure to save up to the matching amount so you don't leave free money behind.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact Principal at 800-547-7754 for details.

Regardless of which retirement account you choose or how much you contribute, remember to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and you may be subject to early withdrawal penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets. The Oceans Healthcare 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, visit **www.principal.com**.

Vesting

Vesting refers to how much of your 401(k) funds you can take with you if or when you leave Oceans Healthcare. With our vesting schedule, each year you'll own a greater percentage of the company's matching contributions. When you're fully vested, you'll own 100% of the contributions. You always own and are fully vested in the contributions you personally make to your 401(k).

VESTING SCHEDULE

YEARS OF SERVICE	PERCENTAGE VESTED
Less than 1	0%
1	20%
2	40%
3	60%
4	80%
5	100%

BENEFITS OF 401(k)

Tax Savings

In a 401(k), you don't owe taxes annually on interest, dividends, or profits earned.

Flexibility

You can change the amount of your contributions any time.

Oceans Healthcare Match

Your retirement savings grows faster with the Company's match!

HOLIDAYS AND PAID TIME OFF

Holidays

This policy shall apply to all regular exempt staff and benefits eligible nonexempt staff required to work on one of the following observed holidays or an alternate date of recognition as announced by Oceans:

The following holidays below will be observed pursuant to the terms of this policy:

- New Year's Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving Day
- Christmas Day

NOTE: For exempt and non-exempt employees who normally conduct business Monday through Friday, in the event the holiday falls on a weekend, will observe the holiday on the Friday directly preceding or the Monday directly following the holiday. If a holiday falls on a Saturday, it will be observed on Friday; if the holiday falls on a Sunday, it is observed on Monday.

Paid Time Off

PTO provides eligible, full-time, employees with paid time away from work that can be used for vacation, personal reasons, sickness, or time off to care for immediate family. PTO must have supervisory approval, and must be scheduled in advance, except in case of sickness or emergency. The PTO policy takes the place of sick, absence, personal time, and vacation. All time away from work should be deducted from the employee's PTO bank in hourly increments with the exception of time off in accordance with company policy for jury duty, military duty, or bereavement.

YEARS OF SERVICE	ANNUAL ACCRUAL PER YEAR	ACCRUAL CAP/CARRY OVER (=YEARLY MAX)
0-1 year	11 days	11 days
1-4 years	16 days	16 days
5 years	22 days	22 days
6-10 years	26 days	26 days
11+ years	30 days	30 days

Please refer to the Company Holiday & PTO Policy for all details and specifications on the above programs.

TUITION REIMBURSEMENT POLICY

Purpose

Tuition or supervision reimbursement is an incentive to eligible employees who wish to pursue further clinical education to enhance current skills or meet the supervision for licensure requirements.

Policy

Tuition or supervision reimbursement up to a maximum of $3,000 per calendar year may be granted to full-time clinical employees. An eligible employee receiving other educational assistance, military education assistance, stipends, or reimbursement of any kind from other sources may be eligible for the tuition reimbursement program, less the amount received from other sources up to an amount not to exceed the total cost of tuition, books, or fees to a maximum of $3,000 per calendar year. Employees who need supervision hours to maintain their licensure are eligible for reimbursement of the costs of those supervisory hours.

The Tuition Reimbursement program does not cover Continuing Education Unit (CEU) required to maintain licenses and certifications.

Definitions

Application – Tuition Reimbursement Application provides all required information, and consents, and must be completed prior to starting course(s). For supervision reimbursement, employees must obtain approval from their supervisor before requesting reimbursement.

Clinical Employee – Employee who performs job responsibilities within the Therapist and Nursing departments and provides direct patient care.

Eligibility

Full-time clinical employees who have been continuously employed at Oceans for 6 months are eligible to apply to the Tuition Reimbursement Program. Part-time and PRN employees are not eligible for tuition assistance. Employees are eligible for supervision reimbursement immediately upon hire.

GLOSSARY

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control over healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Reimbursement Account (HCA) – A personal healthcare account funded by your employer that you can use to pay for qualified medical expenses.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

Minimum Essential Coverage Plan – Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From Oceans Acquisition, Inc. About Your Prescription Drug Coverage and Medicare Under the BCBSTX Core HDHP, BCBSTX Buy-Up HDHP and BCBSTX EPO Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oceans Acquisition, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium

2. Oceans Acquisition, Inc. has determined that the prescription drug coverage offered by the BCBSTX Core HDHP, BCBSTX Buy-Up HDHP and BCBSTX EPO plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Oceans Acquisition, Inc. coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oceans Acquisition, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oceans Acquisition, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2026
Name of Entity/Sender:	Oceans Acquisition, Inc.
Contact—Position/Office:	Human Resources
Address:	5360 Legacy Drive, Suite 101, Plano, TX 75024
Phone Number:	972-464-0541

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 972-464-0541.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 972-464-0541.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Human Resources at 972-464-0541.


OCEANS
HEALTHCARE