BEYOND HEALTH™
BY BEYOND RISK

2026 Benefits Overview

Kelley Oilfield Services, Inc.

Important Contacts

COVERAGE	CONTACT	PHONE	WEBSITE
Medical- #26033 **Personal Health Advocate** Please call first for any health event other than wellness	Personify Health	844-482-5051	https://app.personifyhealth.com Email: beyondhealthsupport@personifyhealth.com
Prescription Drug Benefits	WellDyne	888-479-2000	WellView.WellDyne.com
Virtual Visits	98point6		www.98point6.com/bevcap
Dental	PRINCIPAL	800-986-3343	www.principal.com
Vision	PRINCIPAL	800-986-3343	www.principal.com
Voluntary Worksite Benefits	Aflac	800-992-3522	www.aflac.com
Kelley Oilfield Services Benefits Manager	Laura Kinsey	505-632-2423	l.kinsey@kosinm.com
Benefits Broker	Stephenie Warren	505-326-1111	Stephenie.warren@hubinternational.com
Account Manager	Lana Campbell	505-326-1111	lana.Campbell@hubinternational.com

2

Welcome to your Benefits!

We're excited to offer you a comprehensive selection of competitive benefits that play an essential role in your overall compensation package. You have the freedom to choose from a variety of options to ensure the health and well-being of you and your family, as well as to provide financial security in unexpected situations. This guide has been created to address common questions you may have regarding your benefits. We encourage you to take the time to review it thoroughly, ensuring you fully understand the benefits available to you and your family, and remember to take action before the enrollment deadline. Open Enrollment deadline is 11/21/2025 unless you are a new hire.

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 Required Notices for more details.

In this guide you will find:

HEALTH CARE COVERAGE REMINDER
You may purchase insurance through the Marketplace only if you experience a Qualifying Life Event or during Open Enrollment. The federal Marketplace Open Enrollment dates are from November 1 through January 15. Refer to the Required Notices in this guide for additional details.

3

Eligibility

If you work at least 30 hours per week, you are eligible for benefits. Your benefits are effective 1st of the month following 60 days from your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and 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

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your medical and dental coverage unless you have a Qualified Life Event. If you do not contact Human Resources within 31 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

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

4

Medical Plan

KELLEY OILFIELD SERVICES, INC OFFERS A MEDICAL PLAN, MANAGED BY BEYOND HEALTH AND ADMINISTERED BY PERSONIFY HEALTH.

SAVE WHEN YOU USE IN-NETWORK PROVIDERS

The PPO medical plan allows access to both In-Network and Out-of-Network providers, but you will get better discounts and pay less money by remaining In-Network. When you use providers from within the Cigna network, you receive the benefits at the discounted network cost. If you use non-PPO providers, you will pay more for services. All Out-of-Network services are subject to the amount determined to be eligible by the health plan, and you are responsible for all charges over this allowance.

Provider Network: Cigna

HOW TO FIND AN IN-NETWORK PROVIDER

Looking for physicians who participate in your health insurance network? Use one of these easy ways to find out who's in-network and potentially save money:

» Contact Personal Health Advocate at **844-482-5051**

» Visit www.hcpdirectory.cigna.com

PREVENTATIVE CARE AT NO COST TO YOU

This means you and your covered dependents can access essential services like immunizations and screenings-all at no out-of-pocket expense.

Vaccinations
Stay Protected from disease and other health risk

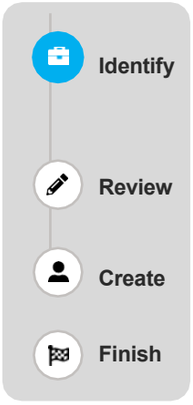
Health Screenings
Identify potential health concerns early, when they may be more easily treated.

Education & Counseling
Access expert advice to support informed health care decisions and lifestyles.

Signing up is easy

ACTIVATE YOUR PERSONIFY HEALTH ACCOUNT

Personify Health simplifies healthcare management. You have access to tools and resources that can help you easily navigate your health plan. Visit **login.personifyhealth.com** or open the app and select **Create an account**.



Follow the progress bar as you complete these easy steps:

Tell us who you are. We'll ask for a few details about you and your sponsor organization to check your eligibility. Have your ID card handy—you'll need your Group ID and Member ID.

Legal and privacy. Review and agree to the rules, data collection and privacy policy.

Create your account. Add your email, make a password and give us some additional details to customize your experience.

You're all set. Your account is ready. Click **Take Me There** to sign in.

Key Features & Benefits -

- Access and download your digital health plan ID card
- View your medical plan status (deductible and out-of-pocket)
- Request new physical ID cards
- Submit and review medical claims
- View Explanations of Benefits (EOBs)
- Find in-network providers and doctors
- Schedule appointments
- Access a licensed clinical team at no cost

Download the app.

personify HEALTH

MEDICAL PLAN OVERVIEW

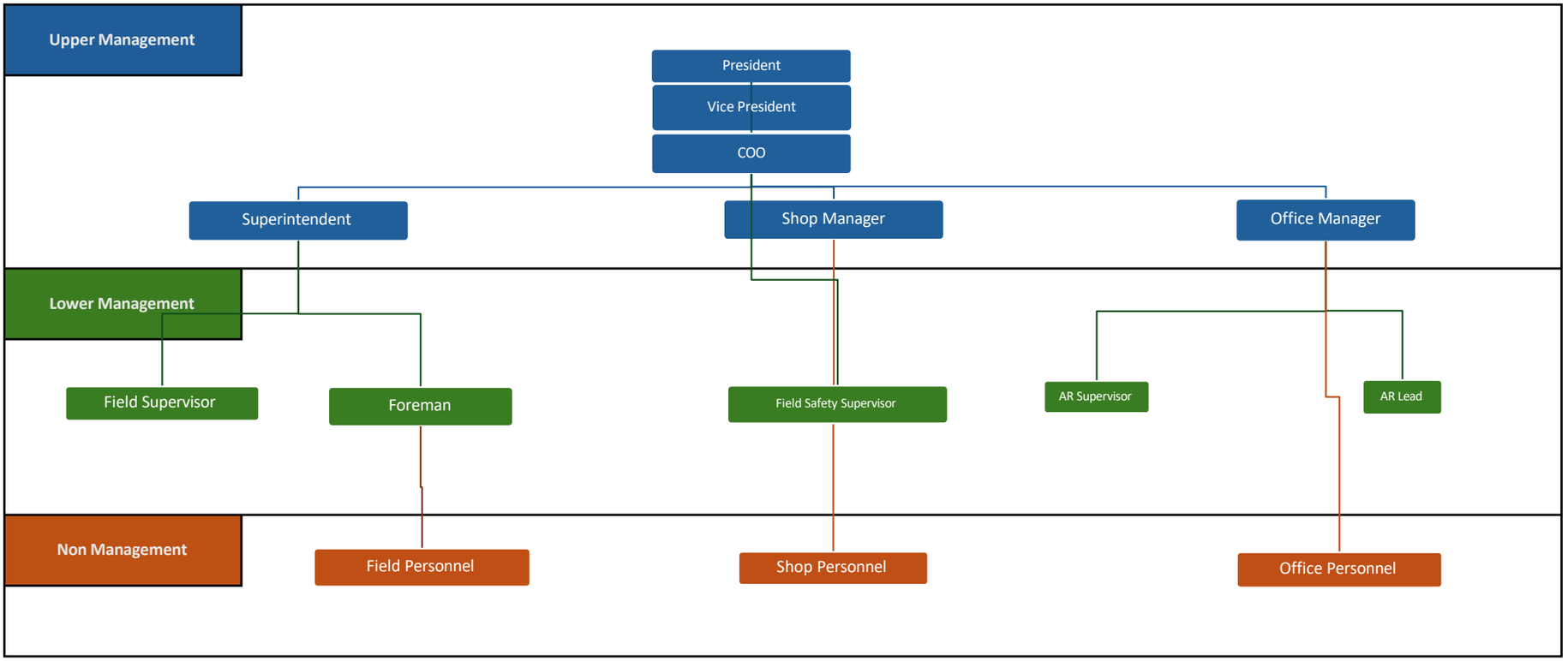
PERSONIFY	PPO PLAN	
	IN-NETWORK	OUT-OF- NETWORK
BASIC INFORMATION		
Deductible (Single/Family)	$4,000/ $8,000	$8,000/ $16,000
Coinsurance (You Pay)	20%	50%
Out-of-Pocket Limit (Single/Family)	$6,000/ $12,000	$12,000/ $24,000
	YOU PAY	
ROUTINE SERVICES		
Virtual Care/Telehealth	$0	
Physician Office Visit	$25 copay	50%*
Specialist Office Visit	$25 copay	50%*
Preventive Services (Adults/Children)	$0	50%*
OTHER SERVICES		
High Tech Radiology (CT, PET, MRI) performed at Preferred Advanced Imaging Provider (Preferred Provider)	$0 (Must be coordinated through Care Navigation Team)	
Surgery Centers (Free Preferred Surgical Centers)	$0 (Must be coordinated through Care Navigation Team)	
HOSPITAL AND FACILITY SERVICES		
Emergency Room Visits	Waived if True Emergency - $750 Penalty	
Urgent Care Visits	$50 copay	50%*
PRESCRIPTION DRUGS		
Tier 1 / Tier 2 / Tier 3	$5/ $25/ $50	N/A
Mail-Order Prescriptions	$10/ $50/ $100	
Specialty	20% of $200 (Tier 1/2) 20% of $250 (Tier 3)	

*After Deductible

MEDICAL PLAN COSTS

MEDICAL - PERPAYCHECK (48 DEDUCTIONS)	PPO PLAN Upper Management	PPO PLAN Lower Management	PPO PLAN Non-Management
Employee	$0.00	$79.28	$107.82
Employee + Spouse	$317.45	$396.73	$425.27
Employee + Child(ren)	$285.57	$364.85	$393.39
Employee + Family	$634.56	$713.84	$742.38
	*Employee Only 100% Employer Paid	*Employee Only 75% Employer Paid	*Employee Only 66% Employer Paid

7


Upper Management
President
Vice President
COO
Superintendent
Shop Manager
Office Manager
Lower Management
Field Supervisor
Foreman
Field Safety Supervisor
AR Supervisor
AR Lead
Non Management
Field Personnel
Shop Personnel
Office Personnel

Prescription Drug Benefits

- Contact WellDyne Customer Care team at **855-876-5483**
- 24/7 Access to Manage prescriptions, setup mail order, drug formulary and pricing, pharmacy locator and more by logging into WellDyne WellView Member Portal at **WellView.WellDyne.com**
- Health and Prescription updates, sign-up for WellConnect text messages through the WellView Member Portal
- **Important Note: Pharmacy Network Does NOT include Walgreens**

Download the WellView mobile app!

Find the WellView icon in Apple or Google Play

WellDyne Drug Savings Programs

Drug Importation Program

International sourcing is a safe, reliable way to get your medication at a lower cost. On behalf of your benefit plan, WellDyne offers drug importation for certain specialty and high-cost maintenance medications.

1. WellDyne will identify members taking an eligible medication.
2. The International sourcing team will contact member via phone call and text to inform them about program and help with enrollment.
3. Receive a 90-day supply of your medical at your doorstep.

Cost Plus Drugs

- Fill a 90 day supply – shipped to your home
- What you pay accumulates towards your deductible and out of pocket
- If you're signed up for WellDyne WellConnect; WellDyne will send you a text message if your medication is available through Cost Plus.

Get started today in 3 easy steps!

Find your medication
Go to **costplusdrugs.com/medications/** to find your generic drugs on our Medication List.

Create your account
Go to **costplusdrugs.com/create-account/** and enter your basic health information. Make sure to complete all steps.

Ask your doctor to send a new prescription to "Mark Cuban Cost Plus Drug Co."
Put the email address you used to create your account on the Rx.

Scan the QR code or visit costplusdrugs.com to get started

Where to Seek Care

TELEMEDICINE

Use telemedicine to seek treatment for minor and easily diagnosable medical conditions. Text/message with a board-certified physician / pediatrician over the phone.

- Colds & flu
- Sore throats
- Headaches
- Stomach aches
- Fever
- Allergies & rashes
- Pink Eye

- FREE! No cost to you!
- Your insurance covers the cost of the consultation.
- Registration takes 5–10 minutes. Consultation calls can take 10–15 minutes. No need to leave home or work.

PRIMARY CARE

See a general practitioner or your primary care physician for routine or preventive care, to keep track of medications and health maintenance.

- General health, immunizations, screenings
- Preventive care
- Routine check-ups

- Physician office visit copay.
- You usually need an appointment.
- Wait times vary based on their appointment schedule.

URGENT CARE CLINIC

Visit an urgent or convenience care clinic to seek treatment for minor medical conditions that may be more urgent or that should be diagnosed in-person. Note: Free-standing ERs are growing in popularity. They look like urgent care clinics, but bill as ERs.

- Colds & flu
- Rashes or skin conditions
- Sore throats, earaches, sinus pain
- Minor cuts or burns
- Pregnancy testing
- Vaccinations
- X-ray

- Urgent care copay.
- It ultimately depends on what codes the facility uses when submitting claims.
- Some clinics take appointments, but walk-ins are most common.

EMERGENCY ROOM

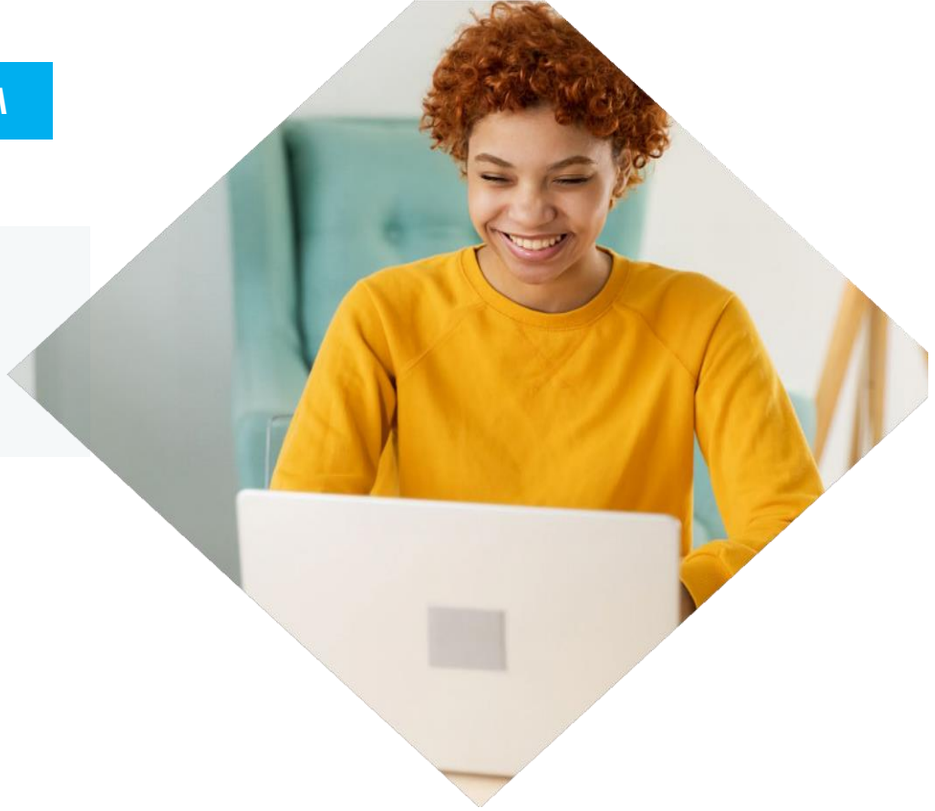
Only visit the ER for immediate treatment of critical or life- threatening injuries or illnesses.

If truly life-threatening, call 911.

- Uncontrolled bleeding
- Compound fractures
- Sudden numbness or weakness
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain
- Head injury or other major trauma
- Blurry vision or loss of vision
- Severe cuts or burns

- ER copay.
- Depending on the extent of services provided, you may be balanced billed.
- Wait times vary but can often be extensive for ERs.

FREE BENEFITS PROGRAM



Virtual Visits: 98point6

98point6 is a great alternative to urgent care and emergency room visits because it provides you 24/7/365 access to U.S. board certified doctors - receive the treatment you need in an easy and timely manner. In addition, you have the ability to send your visit results to your primary care physician. Download the Teladoc app to get started: **http://www.98point6.com/bevcap**.

24/7/365	Quality Doctors	No ER Wait	100% Covered

GET STARTED REMOTE HEALTH CARE CAN TREAT MANY COMMON HEALTH ISSUES

Teladoc doctors can diagnose many health issues like cold and flu symptoms, allergies, rash, skin problems, and so much more! If medically necessary, a prescription will be sent to the pharmacy of your choice.

- Abdominal Pain/Cramps
- Cold and Flu Symptoms
- Respiratory Infection
- Allergies
- Dizziness
- Sinusitis
- Animal/Insect Bites
- Eye Infection
- Sore Throat
- Asthma
- Headaches/Migraines
- Sprains and Strains

10

FREE BENEFITS PROGRAM

Personal Health Advocate

The Personal Health Advocate delivers a higher level of customer service than you've ever experienced and is provided for your insurance needs. The Personal Health Advocate is available to answer your health care questions and guide you through the complexities of your medical plan — at no cost to you. They can also warm transfer for questions related to prior authorization, case management and/or maternity management programs.

FREE MEDICAL CARE

If you require surgery or imaging, contact the Personal Health Advocate to see if the services are eligible for one of the contracted surgery centers for a zero out-of-pocket cost to you.

HOW PERSONAL HEALTH ADVOCATE TAKES CARE OF YOU

BENEFITS

- Encourage appropriate use of recommended prevention care.
- Assist with finding cost effective, high-quality clinical care.
- Connect personal and family needs to available benefits
- Find a Network Provider

CLAIMS

- Ensures deductible and/or co-payments are correct
- Help with claims and billing errors
- Foster communication between member, physicians, and insurance companies

CLINICAL

- Guide members to appropriate level of care for their needs
- Locate lower-cost and hard-to-find drugs
- Identify top medical institutions, specialized medical programs and providers.

FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Personal Health Advocate

beyondhealthsupport@personify.com or call 844-482-5051.

11

FREE BENEFITS PROGRAM

Preferred Surgery Centers

Need surgery? No out-of-pocket costs?

WHAT ARE THE BENEFITS TO USING A PREFERRED SURGERY CENTER?

- Receive high-quality care from top-rated surgeons
- A superior patient experience and outstanding customer service
- Pay nothing out-of-pocket! Your health costs (deductible and coinsurance) are waived*
- Travel expenses for you and an adult caregiver are reimbursable

The following expenses for member and an adult caregiver who travel to the surgery center are covered: mileage, hotel, per diem food allowance during stay and first post-surgery prescription paid.

Member must elect to have surgical procedure performed at one of the plan's Preferred Surgical Centers. A wide range of procedures can be performed at our Preferred Surgical Centers.

Preferred Advanced Imaging Providers

You have access to a concierge scheduling program

for advanced radiology including MRI, CT and PET scans.

WHY USE A PREFERRED IMAGING PROVIDER?

Imaging costs are 100% covered when you utilize an advanced imaging provider by scheduling with a Care Manager, at a time and place convenient to you. By utilizing an advanced imaging network, you have access to a national network with over thousands of facilities.

FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Personal Health Advocate

844-482-5051 or Beyondhealthsupport@personifyhealth.com

* HDHP plans may require annual deductible to be met. Please see your Human Resources contact for more details.

12

Digital Physical Therapy

FREE BENEFITS PROGRAM

Digital Physical Therapy Network uses technology to provide quality, convenient and connected care to patients in the comfort of their own homes. No need to worry about transportation, traffic or the weather. You can safely recover from home, on your schedule, with your licensed physical therapist always available.

HOW IT WORKS

1. When you receive an order for physical therapy, you or your provider may contact the Personal Health Advocate **844-482-5051** to authorize therapy.
2. The Personal Health Advocate will submit authorization and referral on your behalf.
3. The team will contact you to schedule your initial evaluation.

WITH YOUR BENEFIT, GET ACCESS TO:

- Convenient video visits
- Medical Evaluation & diagnosis
- Personalized treatment including physical therapy & more
- Non-opioid pain medication & management if needed
- Support to help you manage pain, regain strength, & enjoy life

GEM Sleep

You now have access to virtual sleep apnea care.

Sleep Evaluation

GEM sleep test includes:

- Testing
- Clinician Review
- Diagnosis
- Treatment recommendation & prescription (if needed)

Sleep Apnea Treatment

GEM makes it easy to get the right treatment:

- Virtual mask fitting
- Multiple treatment options
- Mask & machine guarantee
- CPAPs ready to ship
- Team of experts will help you track your progress
- 1:1 Support
- Live virtual visits available

*If you have a concern of sleep apnea or if you have been diagnosed but not treated, you might qualify for this program.

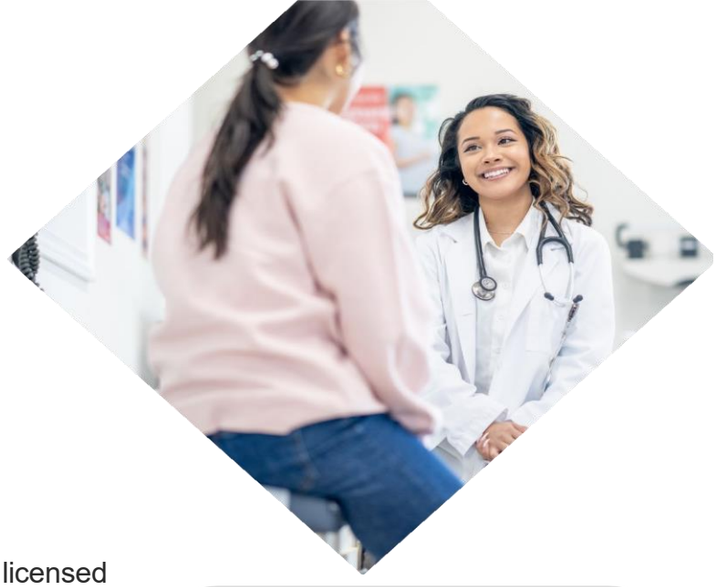
FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Personal Health Advocate

844-482-5051 or Beyondhealthsupport@personifyhealth.com

13

FREE BENEFITS PROGRAM



Chronic Care Management

With chronic care management from Personify Health, a licensed registered nurse will assist and support you as you navigate treatment of your diagnosed condition.

Services:

You'll receive personalized assistance from an assigned clinician who will:

- Provide condition-specific education and support materials.
- Help decrease the frequency or intensity of symptoms and hospitalizations.
- Assist in locating discounted medications.
- Develop a diet management plan tailored to you.

Chronic Conditions Included:

- Congestive heart failure
- Metabolic syndrome
- Diabetes mellitus
- Mental Health
- Asthma
- Chronic obstructive pulmonary disease
- Hypertension
- Substance Abuse

Case Management

Specialized clinicians will work one-on-one with you, your caregiver, healthcare team and health plan to provide personalized assistance when a prolonged, progressive, catastrophic or high-cost illness/condition occurs.

Services:

- Learn about your illness
- Understand your treatment and medications
- Understand what your doctor wants you to do
- Make a self-care plan
- Identify network providers and centers of excellence
- Coordinate specialist referrals
- Explore available medication assistance programs
- Explore community resources
- Understand your health plan benefits
- Navigate the healthcare system

FOR MORE INFORMATION CONTACT THE PERSONAL HEALTH ADVOCATE

844-482-5051 or Beyondhealthsupport@personifyhealth.com

14

Nurturing Together

FREE BENEFITS PROGRAM

Support for Expecting and New Parents

Free program available through your health plan

When you're expecting a baby or caring for a newborn, it helps to have trusted support and guidance. The **Nurturing Together Program**, provided through Personify Health, connects you with a **dedicated prenatal nurse** who can support you throughout your pregnancy and up to **six weeks after delivery**.

How the Program Helps

Your nurse can assist with:

- Understanding pregnancy and newborn care
- Managing pregnancy-related concerns like nausea, diabetes, or high blood pressure
- Finding in-network obstetricians and pediatricians
- Learning about breastfeeding and accessing a breast pump
- Connecting with lactation consultants and community resources
- Answering general parenting and health questions

Free Diapers Incentive

Get a **1-year subscription of free diapers** upon completing the program.
(Must register before the first day of the 3rd trimester — 28 weeks)

Why Enroll

This program is offered **at no cost to you** as part of your benefits.
It's an easy way to get personal guidance and peace of mind during this exciting time.

Get the most from your benefits by enrolling **early in your pregnancy**—or even when you're planning to start a family.

FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Personal Health Advocate

844-482-5051 or Beyondhealthsupport@personifyhealth.com

FREE BENEFITS PROGRAM

Personalized Specialty Infusion Care

Quantify is a national infusion provider that offers local and home-based specialty therapy services. Their integrated model makes specialty therapy care easier and more accessible.

What makes Quantify Different?

- **$0 yearly out-of-pocket expenses***
- **$0 copays for each treatment***
- **In-home infusions available in all 50 states**
- **We provide 24/7 nursing support for all your health needs**

What's Included?

- **Expert care, wherever you are**
- **24/7 clinical support and real-time health insights**
- **Support for your whole health**
- **Precision treatment and medication**

1. If eligible, you will receive a call with information on setting up a consultation to learn more.
2. A dedicated team member will reach out to discuss, and help you enroll in, your treatment plan — whether at home or at one of our 65+ locations nationwide.
3. Our team will work with your current provider to ensure an easy transition to your new specialty care.
4. We'll send you everything you need to prepare for your first home or in-clinic appointment, including simple step-by-step guides to get started.
5. When it's time for your treatment, we make sure everything is ready for an easy experience. Your care team will be there to answer any questions and keep you comfortable.
6. Experience ongoing support with regular check-ins, 24/7 access to your care team, and continuous monitoring to enhance your overall well-being.

16

FREE BENEFITS PROGRAM

FEDlogic

Federal and State Benefit Navigation

A team of experts, ready to help.

FEDlogic is an advocacy service provided by your employer that gives you access to a team of experts who can assist you in understanding federal and state benefit options. FEDlogic's experts have worked for Social Security Administration and have spend years mastering these policies from the inside out. Without education, and advocacy, many individuals don't take advantage of all benefits available to them. FEDlogics' experts can provide you with a peace of mind ensuring that you identify and maximize all of your benefits. FEDlogic does not sell, endorse, or promote any products or services. FEDlogic is a team of unbiased advocates with decades of experience.

Key Programs FEDlogic can assist with:

- Medicare
- Medicaid
- Healthcare.gov
- COBRA
- Social Security Disability
- Social Security Retirement
- State Specific Benefits
- Alternative Healthcare Options
- Survivors Benefits (Widows & Child)
- Premature Baby Birth
- ESRD (Dialysis)
- ALS (Lou Gehrig Disease)
- Terminal Illness
- Cancer
- SSI (Supplemental Security Income)
- Veteran's Benefits
- Tribal Benefits
- Catastrophic Claims

Have questions or want to learn more? Call 877-837-4196 or email services@fedlogicgroup.com for a consultation.

Dental Benefits

ORAL HEALTH IS NOT A LUXURY —IT'S ESSENTIAL TO YOUR OVERALL WELL-BEING

Dental insurance helps make maintaining your oral health more affordable by emphasizing prevention, early detection, and timely treatment. Preventive care, including routine exams and cleanings, is fully covered at no cost to you. For basic and major services, you'll only need to pay a small deductible and coinsurance.

By choosing a dentist within the network, you'll save even more. These providers have agreed to reduced rates, so you'll never pay more than your share of the cost.

PRINCIPAL	LOW PLAN		HIGH PLAN	
	IN-NETW ORK	OUT-OF-NETWORK	IN-NETW ORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
Individual	$50		$50	
Family (3 per family)	$150		$150	
CALENDAR YEAR PLAN MAXIMUM				
Per Individual	$1,500		$3,000	
	YOU PAY			
PREVENTIVE CARE	$0		$0	
BASIC SERVICES	20%		20%	
MAJOR PROCEDURES	50%		50%	
Orthodontics - Child up to age 19	50% $2500 Lifetime Max		50% $2500 Lifetime Max	

DENTAL – PER PAYCHECK (48 DEDCUCTIONS)	LOW PLAN	HIGH PLAN
Employee	$7.07	$8.40
Employee + Spouse	$18.47	$21.95
Employee + Child(ren)	$19.18	$22.85
Employee + Family	$33.74	$39.77

Vision Benefits

HEALTHY EYES AND CLEAR VISION ARE AN IMPORTANT PART OF YOUR OVERALL HEALTH AND QUALITY OF LIFE

The table below summarizes the key features of the vision plan.
Please refer to the official plan documents for additional information on coverage and exclusions.

PRINCIPAL	VSP CHOICE NETWORK	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
COST	**YOU PAY**	
Exam	$10	Up to $45 allowance
Materials	$25	See below
COVERED SERVICES - LENSES		
Single Lenses	$25	Up to $30
Bifocals	$25	Up to $50
Trifocals	$25	Up to $60
Frames	Up to $130 + 20% off balance	Up to $70
COVERED SERVICES – CONTACTS IN LIEU OF FRAMES/LENSES		
Contacts - Medically Necessary	$25	Up to $210
Contacts - Elective	UP to $60 copay for fitting & evaluation $130 allowance for contact lenses	Up to $105
BENEFIT FREQUENCY		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months

VISION - PER PAYCHECK (48 DEDUCTIONS)	
Employee	$1.14
Employee + Spouse	$2.56
Employee + Child(ren)	$2.74
Employee + Family	$4.48

Voluntary Worksite Benefits

Just like it sounds, Supplemental Medical Plans — Accident, Critical Illness, and Hospital Indemnity — are designed to help cover costs that may arise from an injury, illness, or hospitalization. These plans are completely voluntary and offer a one-time, fixed benefit that you can use however you see fit. The funds can help cover out-of-pocket expenses not paid by your primary health insurance, such as deductibles or copays, as well as other costs like lost income, childcare, travel to and from treatment, home health care, or everyday household expenses. Must be enrolled in a qualifying major medical plan to qualify.

Accident Insurance

SAMPLE ELIGIBLE EXPENSE

» Emergency Room Visits

» Medical Exams Including major diagnostic exams

» Fractures and Dislocations

» Hospital Stays

» Physical Therapy

» Transportation and Lodging – if you are away from home when the accident happens

HOW THE PLAN WORKS

» On his way to work, John was in a car accident.

» He was transported by ground ambulance to the emergency room and admitted to the hospital.

» He had a dislocated hip and spent five days in the hospital.

» He had several physical therapy sessions before returning to work.

» John submitted his accident claim and received $5,850 from his accident insurance coverage.

» He used it toward his deductible, copay and supplemental income for his missed workdays.

SAMPLE REIMBURSEMENT	
Ground Ambulance	$250
Emergency Room	$350
MRI	$350
Hospital Stay – Admission + 5 days	$ 9,000
Dislocated Hip	$3,000
Physical Therapy (4 sessions)	$200
TOTAL BENEFIT PAID	**$13,150**

ACCIDENT INSURANCE (MONTHLY RATES)	
Employee	$7.18
Employee + Spouse	$12.66
Employee + Child(ren)	$15.61
Employee + Family	$19.67

Cancer Insurance

While major medical insurance can help with the cost of cancer treatment, you may still have out-of-pocket expenses that are not covered by your major-medical insurance, including travel, food, lodging, childcare and household help. Meanwhile, living expenses such as car payments, mortgage or rent payments, and utility bills continue, whether or not you are able to work. And if a family member has to stop working to take care of you, the loss of income may be doubled.

This policy provides a fixed benefit for the early detection, incidence and treatment of cancer as well as related expenses. You can use the benefit any way you choose—to pay your mortgage, clear debts, or replace lost income, for instance; you do not have to use the benefit to pay for treatment.

The benefits are paid directly to you, unless you choose otherwise. This means you will have additional resources to help with the financial consequences of cancer that may not be covered by major medical insurance.

- No deductible and no copayments
- Fully portable
- Guaranteed renewable
- No network restrictions—you choose your own medical treatment provider

CANCER PROTECTION ASSURANCE 3 - PER PAYCHECK (52 DEDUCTIONS)	
Employee	$9.44
Employee + Spouse	$16.89
Employee + Child(ren)	$9.44
Employee + Family	$16.89

HOW THE PLAN WORKS

- John chooses coverage.
- John has an annual wellness test, is diagnosed with cancer.
- John travels 200 miles for pre-op testing and is admitted to the hospital for surgery.
- In Hospital:
- John has surgery with anesthesia, receives medication and is visited by his doctor during his 3-day stay.
- Out of Hospital:
- Every 2 weeks John has radiation/chemo, is given medication and sees his doctor 3 times. He also purchases a hair prosthesis.

SAMPLE REIMBURSEMENTS	
Wellness Exam	$75
Hospital Confinement	$200
Cancer Initial Diagnosis	$5,000
Non-Local Transportation	$80
Surgery	$1,500
Anesthesia	$375
Radiation/Chemo	$1,600
Medical Imaging	$350
Anti Nausea	$ 100
CASH BENEFIT	$9,875

Hospital Indemnity Insurance

SAMPLE COVERED CONDITIONS

» Hospital Admission

» Hospital Confinement

» Surgical Care

» Medical Diagnostic and Imaging

» Hospital Intensive Care

» Transportation and Lodging

TOTAL BENEFIT PAID	$1,500

HOW THE PLAN WORKS

» In April, Sarah unexpectedly needed back surgery.

» Sarah was admitted to the hospital for surgery.

» After surgery, she began physical therapy to increase her strength and flexibility.

» Sarah submitted her claim and received a lump-sum payment of $1,500.

HOSPITAL CHOICE 1 - PERPAYCHECK (52 DEDUCTIONS)	
Employee	$13.52
Employee + Spouse	$24.47
Employee + Child(ren)	$18.31
Employee + Family	$25.20

Health Benefit Glossary

Coinsurance. A percentage of a health care cost — such as 20 percent — that the covered employee pays after meeting the deductible.

Copayment. The fixed dollar amount — such as $30 for each doctor visit — that the covered employee pays for medical services.

Deductible. A fixed dollar amount that the covered employee must pay out of pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits per person and per family.

Formulary. A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Preferred Provider Option Network (PPO). The PPO means your insurance company will have a network of care providers available to you at your discretion. The care provider will file the claim with your PPO carrier, and you pay the difference between the bill and the insurance payment.

In-network. Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Out-of-network. A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-of-pocket limit. The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Premium. The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Required Notices

Notices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

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

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

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier
than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in this enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

HIPAA Special Enrollment Notice

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 enroll yourself and your dependents in the medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program {CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

Kelly Oilfield Services, Inc
3601 N 1st St
Bloomfield, NM 87413
505-632-2433

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
  The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days (or enter longer period permitted under the terms of the Plan) after the qualifying event occurs. You must provide this notice to your Plan Administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Notices

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or Bis effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.govlagencieslebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov.**

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Kelly Oilfield Services, Inc
3601 N 1st St
Bloomfield, NM 87413
505-632-2433

MEDICARE PART D

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with our Medical Plan 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. We have determined that the prescription drug coverage offered by our Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 coverage with our Medical Plan will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage with our Medical Plan, be aware that you and your dependents may not be able to get this coverage back.

MEDICARE PART D

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

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through our Medical Plan 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 (H300-633-4227) TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember, keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Kelly Oilfield Services, Inc
3601 N 1st St
Bloomfield, NM 87413
505-632-2433

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..12

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

Kelly Oilfield Services, Inc
3601 N 1st St
Bloomfield, NM 87413
505-632-2433

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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

Kelly Oilfield Services, Inc
3601 N 1st St
Bloomfield, NM 87413
505-632-2433

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Notices

GEORGIA – Medicaid	INDIANA – 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	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)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Notices

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Benefit Premiums During Leave Without Pay

If you are placed on a **Leave Without Pay (LWOP)** status, **you are responsible for paying the full cost of your benefit premiums** (both the employee and employer portions) during your absence.

You must **notify the employer within one (1) week** of the start of your leave to arrange premium payments. Failure to make timely payment arrangements or to remit required premiums may result in **cancellation of your benefits**.

If your benefits are cancelled due to nonpayment, coverage will terminate effective the last day of the month for which premiums were paid, and you may not be able to reinstate coverage until the next open enrollment period, or a qualifying life event occurs.

Minimum Essential Coverage (MEC) Plan Notice

Kelley Oilfield Services, Inc. offers employees access to a **Minimum Essential Coverage (MEC) plan**, which satisfies the Affordable Care Act's requirement that individuals maintain basic health coverage.

This plan provides preventive and wellness benefits as defined by the ACA but does **not provide major medical coverage** or meet the ACA's Minimum Value standard.

Eligible employees may elect this plan during open enrollment or within 30 days of a qualifying life event. For complete plan details and rates, please contact Human Resources.

Notice of Benefit Costs and Contributions

The cost of benefits and the level of employer and employee contributions are subject to change each plan year. Adjustments may be made based on economic conditions, insurance market factors, plan performance, and renewal rates.

While Kelley Oilfield Services, Inc. strives to provide quality benefits at a reasonable cost, we reserve the right to modify, increase, or decrease employee contribution amounts and/or employer contributions at any time. Any changes will be communicated to employees prior to the start of the plan year or as soon as practicable.

Kelley Oilfield Services, Inc.

BEYOND HEALTH™
BY BEYOND RISK

2026 Benefits Overview

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